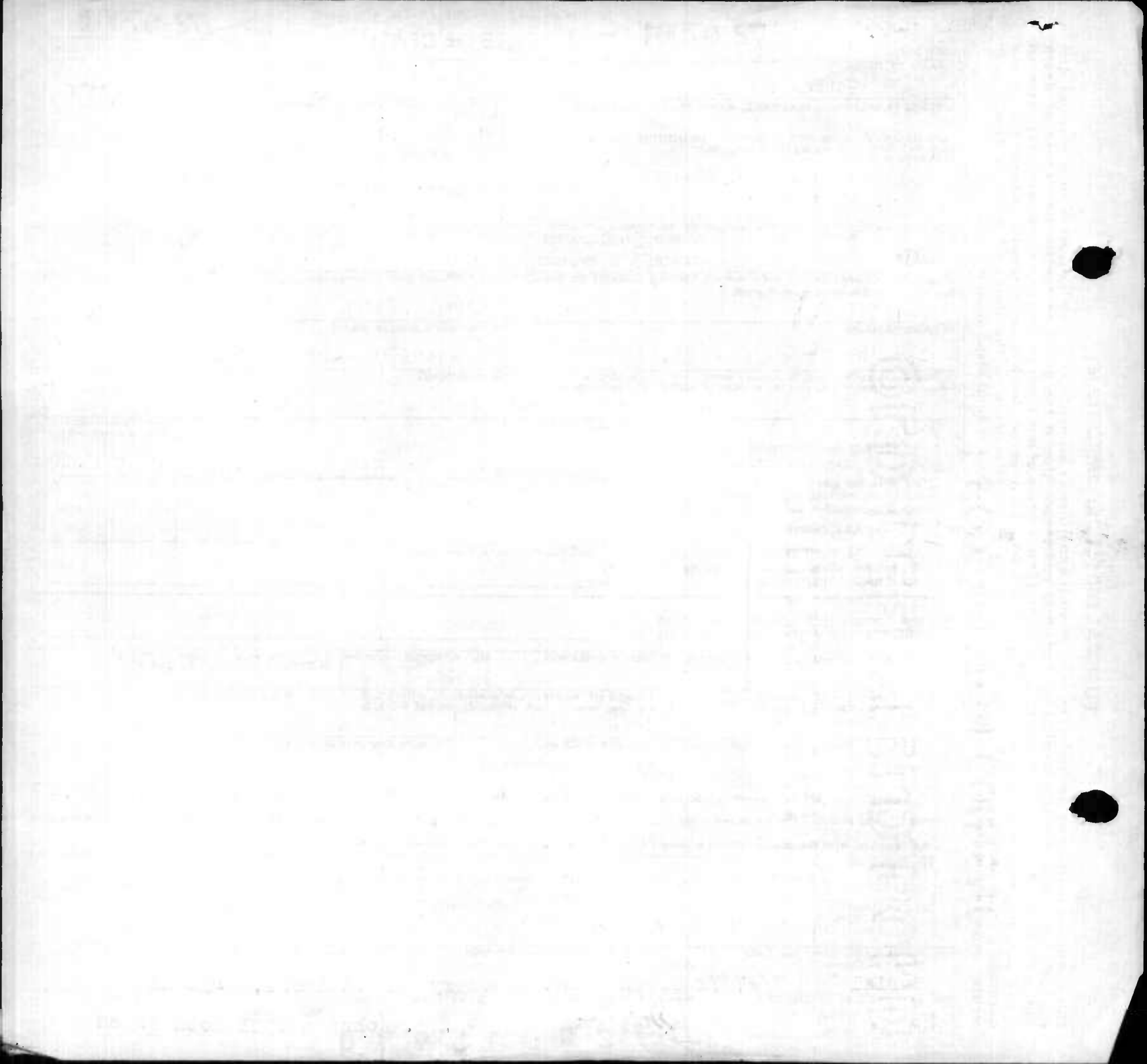


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| E-241 | | 72 07001 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07001 | |
|--|-------------------------|---|--|--|---|---|---|
| BIRTH NO. | | | | STATE OF MARYLAND-DBMH | | | |
| 1. NAME OF DECEASED (Type or Print) EUGENE EICHELBERGER | | | | 2. DATE AND HOUR OF DEATH JULY 24, 1972 8:15 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSP. 7827 LINDEN AVE. BALTIMORE, MD. 21201 | | | | A. STATE MARYLAND B. COUNTY 1102 | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 900 CATHEDRAL ST. | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH SEPT. 7, 1914 | 9. AGE (In years (last birthday)) 57 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHIROPRACTOR | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTO., MD. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME EUGENE T. EICHELBERGER | | | | 14. MOTHER'S MAIDEN NAME MILDRED ROSENTHAL | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 2/9/43 - 9/11/45 | | 16. SOCIAL SECURITY NO. 216-07-2844 | | 17. INFORMANT (SISTER) MRS. VALERIE WRIGHTSON | | ADDRESS 2513 MICHAEL LAKE BALTO., MD. 21234 | |
| 18. 788.6 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE Fever of Unknown Origin DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH about 3 days | |
| | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from JULY 22 19 72 to JULY 24 19 72 that (I) (we) last saw the deceased alive on JULY 24 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Raymundo T. Maclary | | | | MED. DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED JULY 24, 1972 | |
| 23C. PHYSICIAN'S NAME (Type) RAYMONDO T. MACLARY MD | | | | 23D. ADDRESS MARYLAND GEN. HOSP. 827 LINDEN AVE. BALTO., MD. 21201 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/27/72 | | 24C. NAME OF CEMETERY or CREMATORY Green Mount Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Sidney Johnson | | 25C. FUNERAL DIRECTOR Wm. E. Johnson | | ADDRESS 8521 Loch Raven | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07002 | |
|--|-------------------------|--|------------------------------------|--|---|
| 72 07002 | | | | STATE OF MARYLAND-DEME | |
| BIRTH NO. K-460 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Emma Kahl | | 2. DATE AND HOUR OF DEATH 7/22/72 11:30 P. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 90 Haven Nursing Home ADDRESS OR LOCATION 3939 Penhurst | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1510 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3939 Penhurst | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/13/86 | 9. AGE (In years last birthday) 86 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Henry Kahl (late) | | 14. MOTHER'S MAIDEN NAME Mary Kahl (late) | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 215-09-5227 | | 17. INFORMANT ADDRESS C. Edward Hoerichs 1815 Frederick Avenue 21223 | |
| 18. 440.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 3 Informative / Ege (B) Generalized Atherosclerosis (C) Degenerative State | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from June 19 1972 to 7-22 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) and (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Thos G. Abbott | | 23B. DATE SIGNED 7-24-72 | | 23C. PHYSICIAN'S NAME (Type) Dr. Thos G. Abbott | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/25/72 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Adolph H. Hinton | | 25C. FUNERAL DIRECTOR ADDRESS Witzke, 1630 Edmondson Avenue 21228 | |
| 24D. LOCATION (City, town, or county) Baltimore, Maryland | | 24E. STATE (State) Maryland | | | |

12165-Adm.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07003 | |
|---|----------------------|---|---|---------------------------------|---|
| W-200 | | | | REG. NO. 72 07003 | |
| BIRTH NO. 72-11405 72 07003 | | | | STATE OF MARYLAND-DEME | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| WISE, BABY GIRL "A" | | | JULY 23, 1972 11:05A M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL | | | A. STATE MARYLAND B. COUNTY ANNE ARUNDEL C. CITY OR TOWN GLEN BURNIE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 7863 BALTIMORE ANNAPOLIS BLVD. | | |
| 5. SEX FEMALE | 6. RACE CAUCASIAN | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 07 23 72 | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 32 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) |
| | | | | | MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY? | | | U.S.A. | | |
| 13. FATHER'S NAME WILLIAM S. WISE | | | 14. MOTHER'S MAIDEN NAME CAROL ROMECKI | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS RECORDS OF ST AGNES HOSPITAL WILKENS & CATON AVES. |
| 18. 769.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Prematurity DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | |
| 19. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 0 | | | NO | | |
| 20A. AUTOPSY? (Yes or No) | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| NO | | | NO | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (X) (this hospital) attended the deceased from JULY 23 1972 to JULY 23 1972, that (X) (we) last saw the deceased alive on JULY 23 1972 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXX) view the body after death. | | | 23A. SIGNATURE Auranne Bichanaryin M.D. 23B. DATE SIGNED 7/23/72 | | |
| 23C. PHYSICIAN'S NAME (Type) ARVORANEE BIRHAISONARONGSONGRAM M.D. | | | 23D. ADDRESS BALTO., MD. 21229 ST. AGNES HOSPITAL-CATON & WILKENS AVES | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 7/26/72 | | |
| 24C. NAME of CEMETERY or CREMATORY Glen Haven Cemetery | | | 24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | | 25B. NAME OF REGISTRAR Lidney | | |
| 25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue | | | 25D. ADDRESS 21228 | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07004 | |
|--|------------------|---|---|---|---|
| W-200 72 07004 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. 72-11406 | | | | REG. NO. 72 07004 | |
| 1. NAME OF DECEASED (Type or Print) WISE, BABY BOY "B" | | | 2. DATE AND HOUR OF DEATH JULY 23, 1972 9:30 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL 40 WILKENS & CATON AVES. BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. ANNE ARUNDEL 5200 C. CITY OR TOWN GLEN BURNIE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 7863 BALTO. ANNAPOLIS BLVD. | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 07 23 72 | 9. AGE (In years last birthday) NB | 10. Under 1 Yr. Months: Days: 10 35 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME WILLIAM S. WISE | | |
| 14. MOTHER'S MAIDEN NAME CAROL ROMECKI | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS ST AGNES RECORDS WILKENS & CATON AVES. | | |
| 18. 769.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Prematurity (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) NO | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (X) (this hospital) attended the deceased from JULY 23, 19 72 to JULY 23, 19 72, that (X) (we) lost saw the deceased alive on JULY 23, 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE FEREYDOUN M.D. | | | 23B. DATE SIGNED 7-23-72 | | |
| 23C. PHYSICIAN'S NAME (Type) DEHKHAREGHANI, FEREYDOUN M.D. | | | 23D. ADDRESS WILKENS & CATON AVE. BALTO. MD. 21229 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/26/72 | | 24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | | |
| 25B. NAME OF REGISTRAR Sidney Witzke | | 25C. FUNERAL DIRECTOR ADDRESS Witzke, 1630 Edmondson Avenue 21228 | | | |

WILLIAM T. WISE

JULY 22, 1972

2:32P

BY AIRMAIL
BALTIMORE, MARYLAND
MILKERS & CATTLE
BY AIRMAIL HOSPITAL

NO. 100
GLEN SHIP
1953 CALTO, ANNAPOLIS, MD.

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10:32

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WILLIAM T. WISE

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

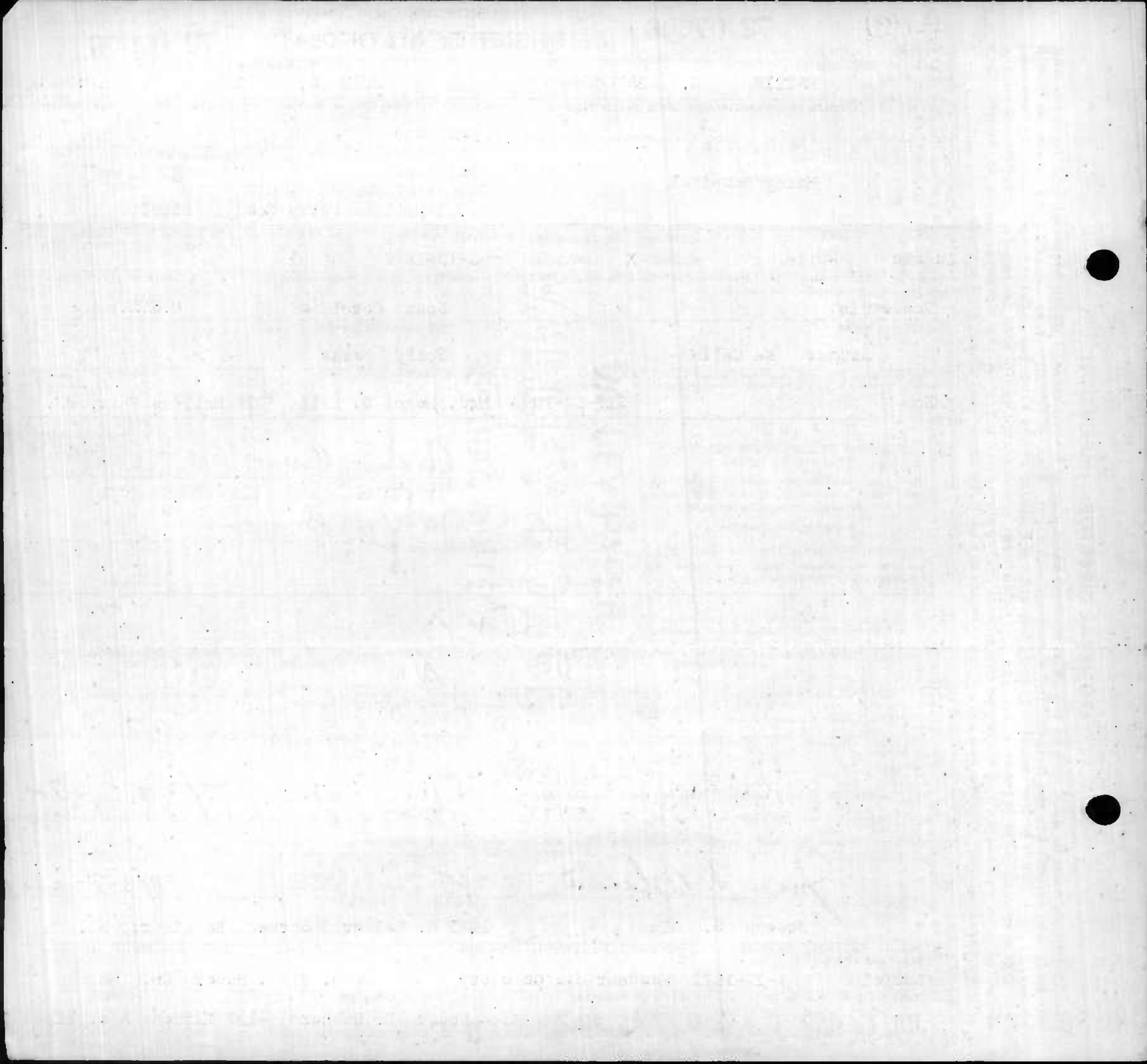
| K-613 | | 72 07005 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07005 | |
|---|--|----------|--|--|--|---|--|
| BIRTH NO. | | | | STATE OF MARYLAND-DHMH | | | |
| 1. NAME OF DECEASED Type or Print FLORIDA KRAFT | | | | 2. DATE AND HOUR OF DEATH 7-24-72 9 30 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BON SECOURS HOSP. 34 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 2854 | | | |
| 5. SEX F | | | | 6. RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 8-24-89 | | | | 9. AGE (in years last birthday) 82 | | 10. Under 1 Yr. Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME George Adam Kraft | | | |
| 14. MOTHER'S MAIDEN NAME Ida M. Kayser | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS Mr. Warren B. Sagman, Falls & Pimlico Rd. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS YEARS | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Probable ACUTE MYOCARDIAL INFARCTION | | | | 20. DATE OF OPERATION 0 | | | |
| 21. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 22. AUTOPSY? (Yes or No) NO | | | |
| 23. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO | | | |
| 25. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year (Hour) 1 Month | | | | 26. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 27. HOW DID INJURY OCCUR? | | | | 28. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location) | | | |
| 29. I certify that (I) (this hospital) attended the deceased from 7-24-1972 to 7-24-1972 that (I) (we) last saw the deceased alive on 7-24-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | 30. SIGNATURE Oscar E. Fernandez M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | |
| 31. DATE SIGNED 7-24-72 | | | | 32. PHYSICIAN'S NAME (Type) OSCAR E. FERNANDINI M.D. | | | |
| 33. ADDRESS BON SECOURS HOSP. | | | | 34. BURIAL CREMATION, REMOVAL (Specify) Burial | | | |
| 35. DATE 7-27-1972 | | | | 36. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery | | | |
| 37. LOCATION Baltimore, Maryland | | | | 38. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | | |
| 39. NAME OF REGISTRAR Sidney Johnston | | | | 40. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | |

1018/57 - Adm.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | STATE OF MARYLAND-DEMH | |
|--|--|---|--|--|--|
| 72 07006 | | | | 72 07006 | |
| <div style="display: flex; justify-content: space-between;"> <div> <p>B-420</p> <p>BIRTH NO.</p> </div> <div> <p>1. NAME OF DECEASED (Type or Print)</p> <p>MATTIE J. BAILES</p> </div> <div> <p>2. DATE AND HOUR OF DEATH</p> <p>JULY 24, 1972 10:20 A.M.</p> </div> </div> | | | | | |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p>37 Mercy Hospital</p> | | | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE Maryland</p> <p>B. COUNTY 2572</p> | | |
| <p>5. SEX</p> <p>Female</p> | | <p>6. RACE</p> <p>White</p> | | <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p> | |
| <p>8. DATE OF BIRTH</p> <p>3-15-1881</p> | | <p>9. AGE (In years last birthday)</p> <p>91</p> | | <p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p>Housewife</p> | |
| <p>11. BIRTHPLACE (State or foreign country)</p> <p>South Carolina</p> | | <p>12. CITIZEN OF WHAT COUNTRY?</p> <p>U.S.A.</p> | | | |
| <p>13. FATHER'S NAME</p> <p>Arthur Mc Collum</p> | | | <p>14. MOTHER'S MAIDEN NAME</p> <p>Polly Banks</p> | | |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p>No</p> | | <p>16. SOCIAL SECURITY NO.</p> <p>217-54-1290</p> | | <p>17. INFORMANT</p> <p>Mrs. Mabel D. Hill, 3021 Hollins Ferry Rd.</p> | |
| <p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>412.4 I</p> | | <p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p>Cardiac Arrest</p> | | <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p>Sudden</p> | |
| <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>A.S.C.V. Disease</p> | | <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>CVA</p> | | <p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>?</p> | |
| <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> | | | | | |
| <p>19A. DATE OF OPERATION</p> <p>0</p> | | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> <p>No</p> | | <p>20A. AUTOPSY? (Yes or No)</p> <p>No</p> | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p> <p><input type="checkbox"/></p> | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | | <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> | |
| <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p> | | <p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | | <p>21F. HOW DID INJURY OCCUR?</p> | |
| <p>22. I certify that (I) (this hospital) attended the deceased from 5/12/72 to 7/24/72, that (I) (we) last saw the deceased alive on 7/24/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | | | | | |
| <p>23A. SIGNATURE</p> <p><i>Joseph S. Blum</i></p> | | | | <p>23B. DATE SIGNED</p> <p>7/25/72</p> | |
| <p>23C. PHYSICIAN'S NAME (Type)</p> <p>Joseph S. Blum</p> | | | | <p>23D. ADDRESS</p> <p>1115 N. Calvert Street, Baltimore, Md.</p> | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p>Burial</p> | | <p>24B. DATE</p> <p>7-27-1972</p> | | <p>24C. NAME OF CEMETERY OR CREMATORY</p> <p>Meadowridge Cemetery</p> | |
| <p>24D. LOCATION (City, town, or county) (State)</p> <p>Wash. Blvd. Howard Co., Md.</p> | | <p>25A. DATE REC'D BY HEALTH DEPT.</p> <p>JUN 27 1972</p> | | | |
| <p>25B. NAME OF REGISTRAR</p> <p><i>Richard Hubbard</i></p> | | <p>25C. FUNERAL DIRECTOR</p> <p>Howard H. Hubbard, 4107 Wilkens Ave. 21229</p> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|----------------------|---|---|
| <div style="display: flex; justify-content: space-between;"> S-320 72 07007 BALTIMORE CITY HEALTH DEPARTMENT </div> <div style="display: flex; justify-content: space-between;"> CERTIFICATE OF DEATH REG. NO. <u>72 07007</u> </div> | | | |
| BIRTH NO. <u>8-320</u> | | STATE OF MARYLAND-DEMH | |
| 1. NAME OF DECEASED (Type or Print) <u>HENRY S. SHEETS</u> | | 2. DATE AND HOUR OF DEATH <u>July 22, 1972</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>34 Bon Secure Hospital</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1927th Pratt St.</u> | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 16, 1906</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>GROCER</u> | 9. AGE (In years last birthday) <u>66</u> |
| 11. BIRTHPLACE (State or foreign country) <u>MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Charles L. Sheets</u> | | 14. MOTHER'S MAIDEN NAME <u>MARY E. Simmons</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, No or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>218-07-2531</u> | |
| 17. INFORMANT <u>Walter A. Sheets</u> | | ADDRESS <u>5502 Syracuse Ave.</u> | |
| 18. <u>250.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Acute coronary occlusion mini</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial heart disease - left</u> years (B) <u>unstable block, Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF: <u>with congestive failure</u> years (C) <u>Diabetes mellitus</u> <u>Nephrosclerosis</u> years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Dec 13</u> 19 <u>67</u> to <u>July 22</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>July 21</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <u>Henry Armanas M.D.</u> | | 23B. DATE SIGNED <u>July 24, 1972</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>HENRY ARMANAS M.D.</u> | | 23D. ADDRESS <u>1934 Wilkens Ave.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>July 26, 1972</u> | |
| 24C. NAME of CEMETERY or CREMATORY <u>Moreland Memorial Park</u> | | 24D. LOCATION (City, town, or county) (State) <u>Parkville Baltimore Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 27 1972</u> | | 25B. NAME OF REGISTRAR <u>Anthony Johnson</u> | |
| 25C. FUNERAL DIRECTOR <u>Amexosa Inc.</u> | | ADDRESS <u>1328 Sulphur Spring Rd.</u> | |

Acute coronary syndrome
Myocardial infarction
Angina pectoris
Dilated cardiomyopathy
Hypertension

Page 12

Dr. J. R. Smith

For information only

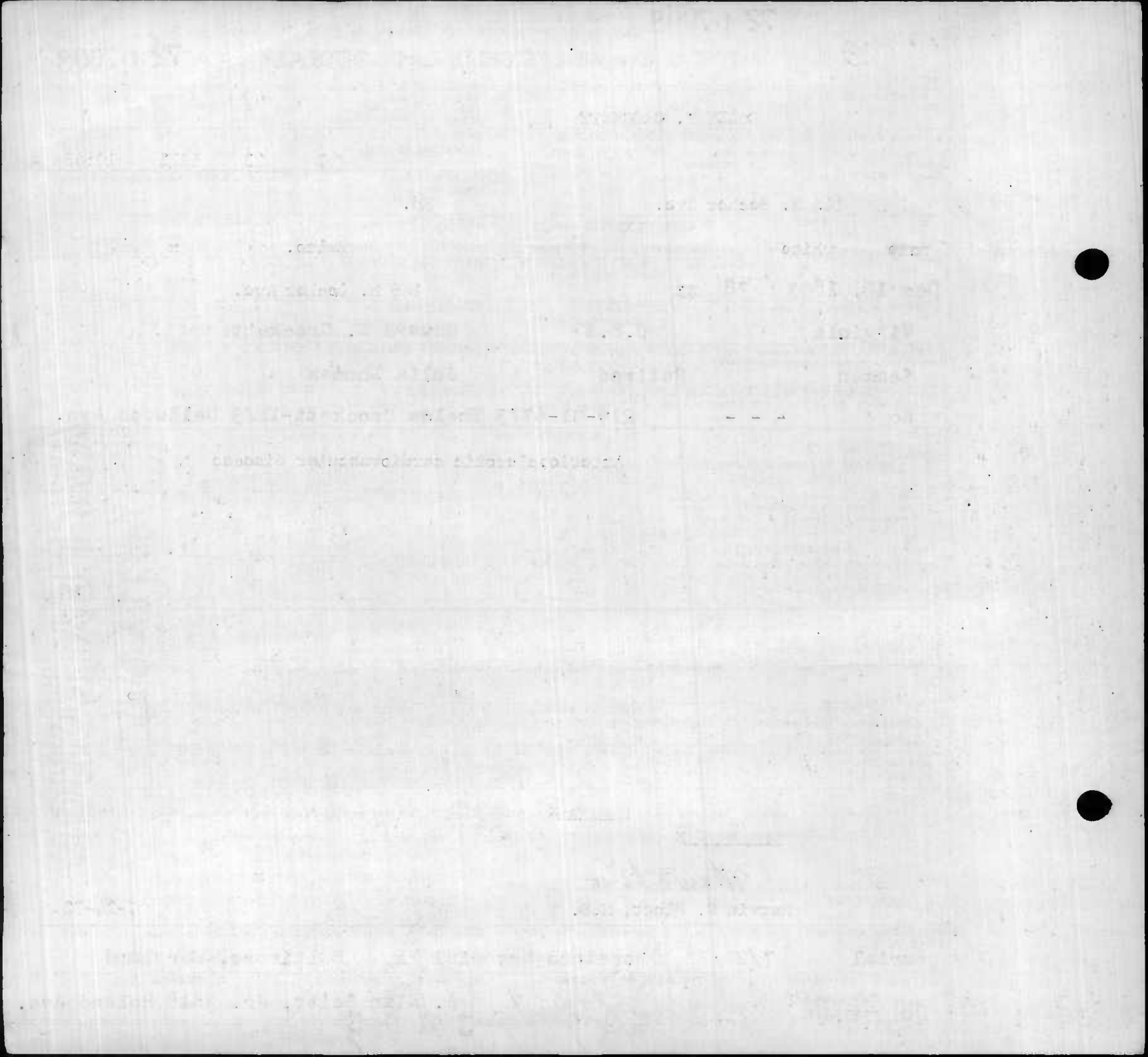
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07008

BIRTH NO.

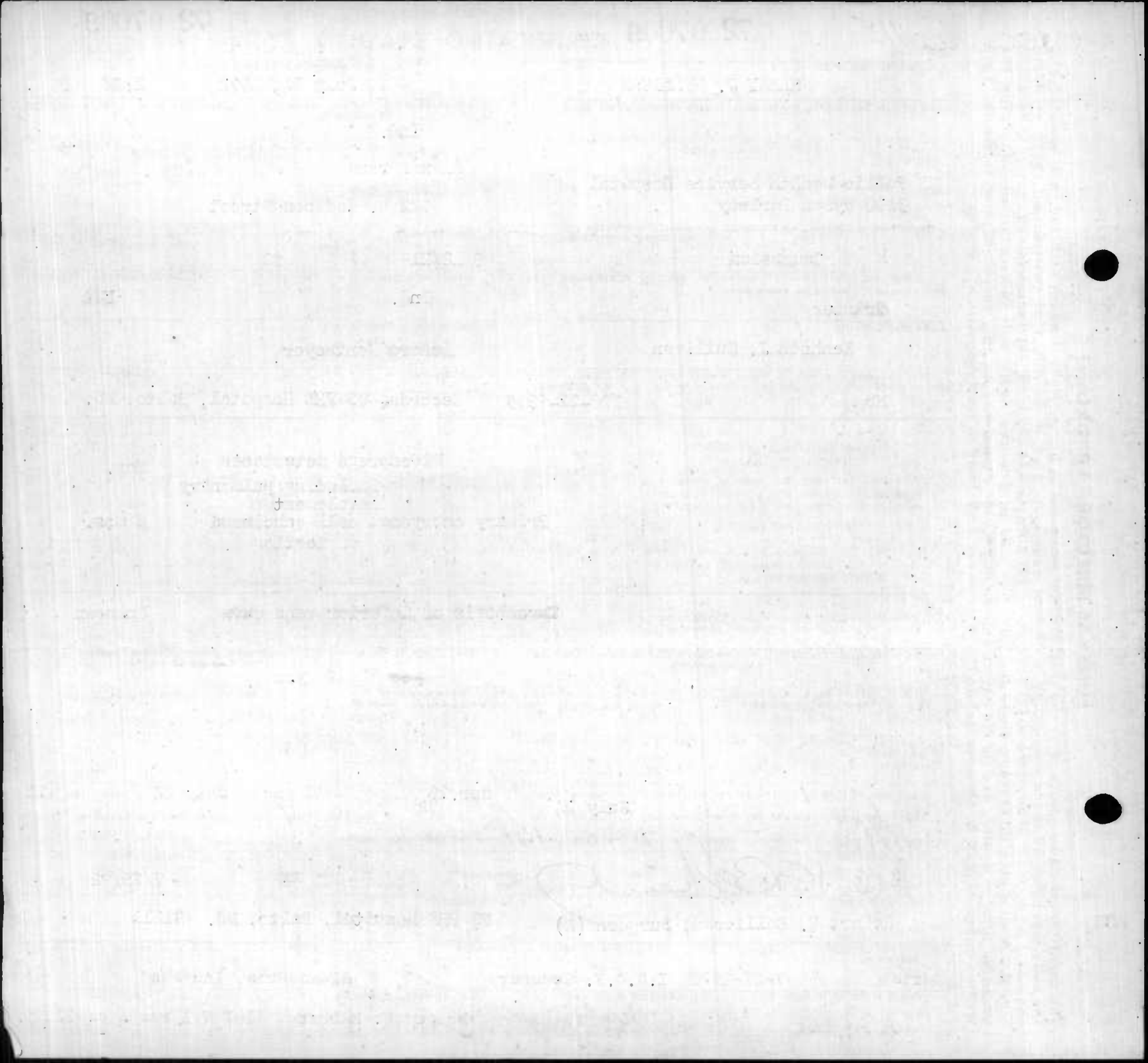
| | | | |
|--|-------------------------|---|---|
| 1. NAME OF DECEASED (Type or Print) COLEY F. CROCKETT | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 146 N. Decker Ave. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 23 1972 10:45p M. | |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 601 | | | |
| 6. SEX male | 7. RACE white | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN Balto. |
| 9. DATE OF BIRTH Dec 12, 1893 | | 10. AGE (In years last birthday) 78 73 | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF U.S.A. | E. STREET AND NUMBER 146 N. Decker Ave. |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman | | 14B. KIND OF BUSINESS OR INDUSTRY Retired | 15. MOTHER'S MAIDEN NAME Julia Thomas |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 219-01-6773 | 18. INFORMANT ADDRESS Thelma Crockett-1223 Dellwood Ave. |
| 19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED no | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. DATE SIGNED 7-24-72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/27/72 | 24C. NAME of CEMETERY or CREMATORY Moreland Memorial Pk |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Adrian H. Houston | 25C. FUNERAL DIRECTOR ADDRESS A. Alan Seitz, Jr. 3818 Roland Ave. |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07009 | |
|---|--|---|--|---|--|
| 72 07009 | | | | STATE OF MARYLAND-DHMH | |
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) HARRY J. SULLIVAN | | 2. DATE AND HOUR OF DEATH July 24, 1972 2:28 P. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 3100 Wyman Parkway | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Ind. B. COUNTY V 12 C. CITY OR TOWN Alexandria D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 722 W. Madison Street | | | |
| 5. SEX M | 6. RACE Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/12/21 | 9. AGE (In years last birthday) 50 | 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer |
| 10B. KIND OF BUSINESS OR INDUSTRY Printer | | 11. BIRTHPLACE (State or foreign country) Ind. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Kenneth J. Sullivan | | | 14. MOTHER'S MAIDEN NAME Lenora Zentmeyer | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 308-22-9255 | | 17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md. | |
| 18. CAUSE OF DEATH | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Widespread metastases ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Primary embryonal cell carcinoma of testis | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Mos. 8 mos. | |
| II | | | | Thrombosis of inferior vena cava | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | Unknown | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Apr. 26 19 72 to July 24 19 72 , that (I) (we) last saw the deceased alive on July 24 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert E. Belliveau | | | | 23B. DATE SIGNED 7/25/72 | |
| 23C. PHYSICIAN'S NAME (Type) Robert E. Belliveau, Surgeon (R) | | | | 23D. ADDRESS US PHS Hospital, Balto, Md. 21211 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-27-1972 | | 24C. NAME of CEMETERY or CREMATORY I.O.O.F. Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Alexandria, Indiana | | 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 25B. NAME OF REGISTRAR Howard N. Hubbard | | | |
| 25C. FUNERAL DIRECTOR ADDRESS Howard N. Hubbard, 4107 Wilkens Ave. 21229 | | | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07010

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) <i>ie</i> Ann G. King | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>00</i> 1126 Riverside Drive | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 25 72 9:23 a. M. | |
| 6. SEX female | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH April 19, 1898 | | 10. AGE (In years lost birthday) 78 4 | |
| 11. BIRTHPLACE (State or foreign country) Balto. Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 14B. KIND OF BUSINESS OR INDUSTRY Home | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT Mr. Harvey King, Jr. | | ADDRESS 107 First Ave. Lansdowne, Md. | |
| 19. 412-4 | | CAUSE OF DEATH Arteriosclerotic cardiovascular disease | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: FSCUD | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-27-72 | |
| 24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Sidney [Signature] | |
| 25C. FUNERAL DIRECTOR McCully-130 E. Fort Ave. Balto. Md. 21230 | | ADDRESS | |

8-1-1972 - Letter from the Office of the Chief Medical Examiner, Peter Lipkovic, M.D.

Assistant Medical Examiner

HRS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07011

BIRTH NO.

| | | | |
|--|-------------------------|---|--|
| 1. NAME OF DECEASED (Type or Print) George Hopkins | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 900 Cathedral St. - Room 407 | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 23 72 8:35 a. M. | |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1102 | | | |
| 6. SEX male | 7. RACE White | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH | | 10. AGE (In years lost birthday) 73 | |
| 11. BIRTHPLACE (State or foreign country) Colorado | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME George P Hopkins | | 14. MOTHER'S MAIDEN NAME Ellen Guffey | |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired clerk | | 16. KIND OF BUSINESS OR INDUSTRY Racing | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No, if unknown) (If yes, give war or dates of service) no | | 18. SOCIAL SECURITY NO. 213 28 9414 | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) no | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/23/72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/26/72 | |
| 24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery | | 24D. LOCATION (City, town, or county) (State) Woodlawn Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Sidney [Signature] | |
| 25C. FUNERAL DIRECTOR Mitchell Wiedefeld Home | | 25D. ADDRESS 6500 York Rd | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07012

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Dorothy J Haines | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 7 24 72 | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 810 Cathedral St. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 24 72 11:45 a.m. | |
| 6. SEX female | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH June 12, 1916 | | 10. AGE (In years last birthday) 56 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Baltimore | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Wilson L. Haines | | 14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1102 | |
| 15. MOTHER'S MAIDEN NAME Naomi Von Eiff | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT ADDRESS Mrs. Albert Clark 6829 Blenheim Rd | |
| 19. 571.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20. DATE OF OPERATION | | 21. AUTOPSY? (Yes or No) Yes - partial | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/24/72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/26/72 | |
| 24C. NAME of CEMETERY or CREMATORY Druid Ridge | | 24D. LOCATION (City, town, or county) (State) Pikesville, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Lidney | |
| 25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home | | 25D. ADDRESS 6500 York Road | |

8-1-1972 - Letter from the Office of the Chief Medical Examiner, Peter Lipkovic, M.D.

Assistant Medical Examiner

HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07013 | |
|---|------------------------|---|---|---|---|
| 72 07013 | | | | STATE OF MARYLAND - DHMH | |
| BIRTH NO. | | | | M. | |
| 1. NAME OF DECEASED (Type or Print) JAMES C. REDMOND, SR. | | | 2. DATE AND HOUR OF DEATH July 23, 1972 | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 Bon Secours Hospital | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2003 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2045 Wilkens Avenue | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-1-1893 | 9. AGE (In years last birthday) 79 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Truck Driver | | 10B. KIND OF BUSINESS OR INDUSTRY W.T. Cowen Co. | 11. BIRTHPLACE (State or foreign country) Minnesota | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME James Redmond | | | 14. MOTHER'S MAIDEN NAME Margaret (Unknown) | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-01-7099 | 17. INFORMANT ADDRESS 21061 Mr. Vincent R. Mileo, Jr. 515 Glenbrook Rd. | | |
| 18. 410.9 + 154.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CAUSE OF DEATH Acute Myocardial infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD + COPD. (B) DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Rectosigmoid. (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-05 1971 to 7-23 1972, that (I) (we) last saw the deceased alive on 7-20 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE M.F. Albuerne | | | 23B. DATE SIGNED 7-24-72 | | |
| 23C. PHYSICIAN'S NAME (Type) M.F. Albuerne | | | 23D. ADDRESS 7935 PIPERS PATH Glen Burne Md 21061 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 7-26-1972 | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Sidney H. Hubbard | | 25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229 | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| E-450 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07014 | |
|--|------------------|---|------------------------------|---|---|
| BIRTH NO. | | 72 07014 | | REG. NO. 72 07014 | |
| 1. NAME OF DECEASED (Type or Print) | | STATE OF MARYLAND-DEME | | | |
| Clara Emo | | 2. DATE AND HOUR OF DEATH 7-24-72 1:20 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY Maryland WASH. | | | |
| Park Hill Nursing Home 1802 Eutaw Place Baltimore, Maryland | | C. CITY OR TOWN FUNKTOWN | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 16 E. GREEN STREET 21734 | | | |
| 5. SEX F | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-8-1892 | 9. AGE (In years last birthday) 80 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Employed | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Penn. | |
| 13. FATHER'S NAME David Fyler | | 14. MOTHER'S MAIDEN NAME Elizabeth Lytel | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213-10-2584 | | 17. INFORMANT Mr. Robert E. Harvie, 16 E. Green St. 21734 PARK HILL Nursing Home, 1802 Eutaw Pl | |
| 18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. If means the disease, injury or complication which caused death.) diabetes mellitus | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: AS CVD | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several years | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO OR AS A CONSEQUENCE OF: several years | | | |
| (C) | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 20 1972 to 7-24 1972 that (I) (we) last saw the deceased alive on 7-23-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE E. Ellsworth Cook MD | | | | 23B. DATE SIGNED 7-24-72 | |
| 23C. PHYSICIAN'S NAME (Type) E. Ellsworth Cook MD | | | | 23D. ADDRESS 2431 Md. Ave. Balto. Md. 21272 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-26-1972 | | 24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Lidney | | 25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229 | |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| <p>G-150 72 07015 BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;">CERTIFICATE OF DEATH</p> | | <p>72 07015</p> <p>REG. NO. STATE OF MARYLAND-DHMH</p> | |
| <p>BIRTH NO. 6-150</p> <p>1. NAME OF DECEASED (Type or Print) GAFFIN, DINA</p> | | <p>2. DATE AND HOUR OF DEATH 7-25-72 6-30 P.M.</p> | |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL</p> | | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE MD B. COUNTY 2843</p> | |
| <p>5. SEX FEMALE 6. RACE WHITE</p> <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p> | | <p>8. DATE OF BIRTH XXXXXXXXXX 9. AGE (In years last birthday) XX 89</p> | |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXXXXXX HOUSEWIFE</p> | | <p>10B. KIND OF BUSINESS OR INDUSTRY AT HOME</p> | |
| <p>11. BIRTHPLACE (State or foreign country) LITHUANA</p> | | <p>12. CITIZEN OF WHAT COUNTRY? USA</p> | |
| <p>13. FATHER'S NAME KALMAN GERBER</p> | | <p>14. MOTHER'S MAIDEN NAME BESSIE ?</p> | |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO</p> | | <p>16. SOCIAL SECURITY NO. H. MILTON LASSON, #6001 WALLIS AVENUE #21215</p> | |
| <p>18. 4270 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.</p> | | <p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p> | |
| <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> | | <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> | |
| <p>19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> | | <p>20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/></p> | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | |
| <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | | <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p> | |
| <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | | <p>21F. HOW DID INJURY OCCUR?</p> | |
| <p>22. I certify that (I) (this hospital) attended the deceased from 7-13-1972 to 7-25-1972 that (I) (we) last saw the deceased alive on 7-25-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | | | |
| <p>23A. SIGNATURE H. Siddigi M.D. DEGREE</p> | | <p>23B. DATE SIGNED</p> | |
| <p>23C. PHYSICIAN'S NAME (Type) JASED H. SIDDIGI M.D. DEGREE</p> | | <p>23D. ADDRESS Lutheran Hospital</p> | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL</p> | | <p>24B. DATE 7/26/72</p> | |
| <p>24C. NAME OF CEMETERY or CREMATORY MIKRO KODESH</p> | | <p>24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND</p> | |
| <p>25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972</p> | | <p>25B. NAME OF REGISTRAR Dorothy Johnston</p> | |
| <p>25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</p> | | <p>ADDRESS</p> | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-55372 07016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 72 07016

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED (Type or Print) SAMUEL Leon Kaminetz

2. DATE AND HOUR OF DEATH 7/25/72 5:20 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY BALTO

5. CITY OR TOWN Baltimore

6. INSIDE CITY LIMITS? YES ☒ NO ☐

7. STREET AND NUMBER 1-D

8. CITY OR TOWN Baltimore

9. INSIDE CITY LIMITS? YES ☒ NO ☐

10. STREET AND NUMBER 6930 Brookmill Road Apt. 21215

9. SEX Male

10. RACE Caucasian

11. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

12. DATE OF BIRTH JULY 7, 1910

13. AGE (In years last birthday) 62

14. If Under 1 Yr. Months Days

15. If Under 24 Hrs. Hours Min.

16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED

17. KIND OF BUSINESS OR INDUSTRY REAL ESTATE

18. BIRTHPLACE (State or foreign country) Maryland, BALTIMORE

19. CITIZEN OF WHAT COUNTRY U.S.A.

20. FATHER'S NAME Joseph KAMINETSKY

21. MOTHER'S MAIDEN NAME Hattie SEGALOFF

22. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO

23. SOCIAL SECURITY NO. 215-10-3313

24. INFORMANT MRS. ROSE KAMINETZ, 6930 BROOKMILLS ROAD #15

25. ADDRESS 6930 BROOKMILLS ROAD #15

26. CAUSE OF DEATH

27. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

28. ANTECEDENT CAUSES

29. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

30. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebrovascular Accident 24 hrs

31. DUE TO, OR AS A CONSEQUENCE OF: Hypertension

32. DUE TO, OR AS A CONSEQUENCE OF: Chronic Renal Failure

33. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). none

34. DATE OF OPERATION 7/21/72

35. CONDITION FOR WHICH OPERATION WAS PERFORMED Bleeding From Fistula in sigmoid

36. AUTOPSY? (Yes or No) NO

37. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

38. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No

39. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) Not applicable

40. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N.A.

41. TIME OF INJURY (Month) (Day) (Year) (Hour) N.A.

42. INJURY OCCURRED While At Work ☒ Not While At Work ☐ N.A.

43. HOW DID INJURY OCCUR? N.A.

44. I certify that (I) (this hospital) attended the deceased from 7-21-19 72 to 7-25-19 72 that (I) (we) last saw the deceased alive on 7-25-19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

45. SIGNATURE Robert F. Draper MD

46. ATTENDING PHYS. Med. Director ☐ Staff Phys. ☒

47. DATE SIGNED 7/25/72

48. PHYSICIAN'S NAME (Type) Robert F. Draper

49. ADDRESS Baltimore City Hospitals

50. ADDRESS 4940 Eastern Avenue, Baltimore, Md. 21224

51. BURIAL CREMATION, REMOVAL (Specify) BURIAL

52. DATE 7/26/72

53. NAME OF CEMETERY OR CREMATORY ADATH YESHURUN (SODOVA)

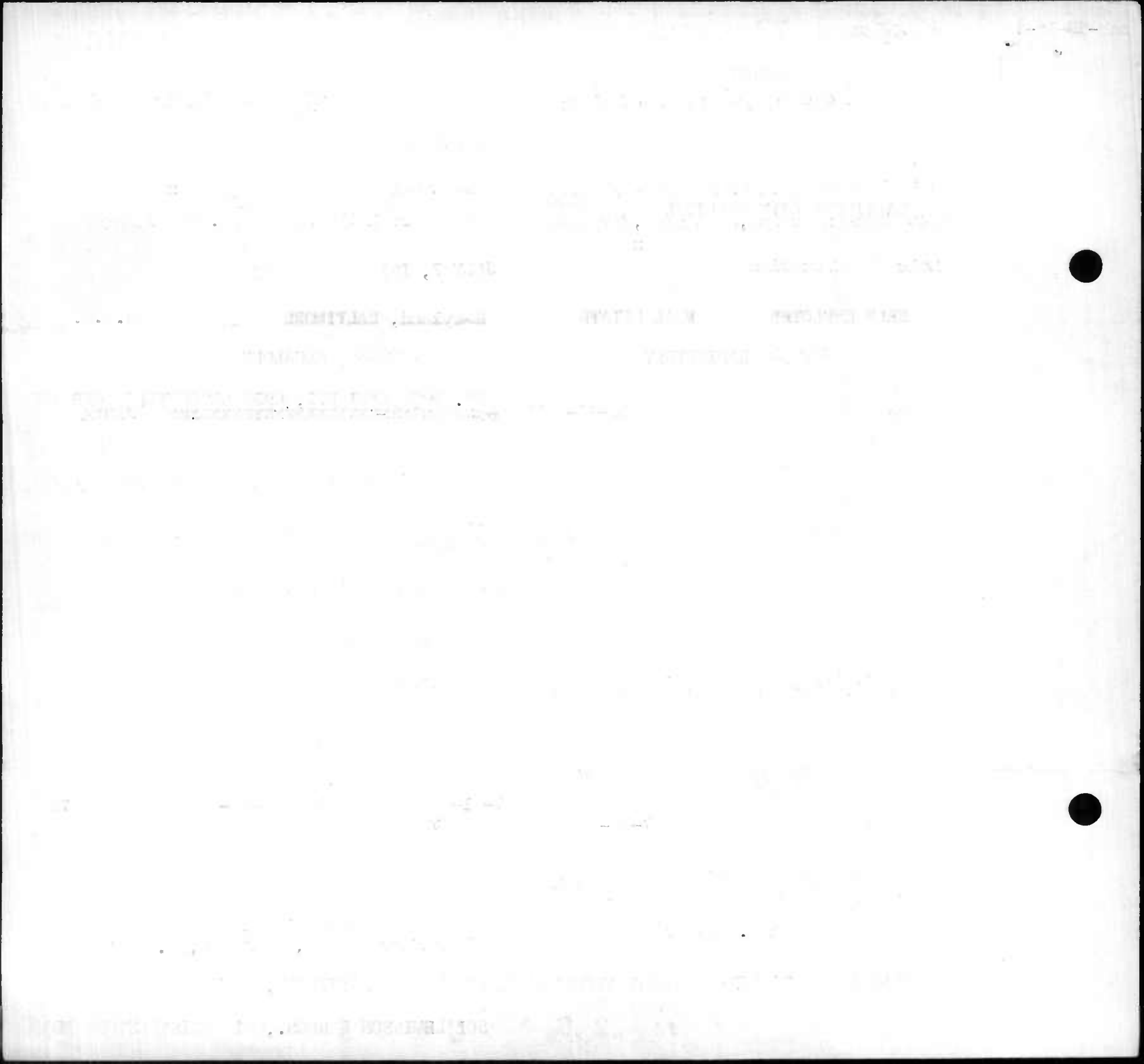
54. LOCATION BALTIMORE, MARYLAND

55. DATE REC'D BY HEALTH DEPT. JUL 27 1972

56. NAME OF REGISTRAR

57. FUNERAL DIRECTOR SOLE LEVINSON & BROS., 6010 REISTERSTOWN ROAD

58. ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | | | |
|---|-------------------------|---|------------------|---|----------------------------|---|-----------------------------|--|--|
| 7426 BIRTH NO. | | 72 07017 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07017 | | STATE OF MARYLAND-DHMH | |
| 1. NAME OF DECEASED (Type or Print) SARA FLEXER | | | | 2. DATE AND HOUR OF DEATH JULY 23, 1972 10:30 P.M. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 14 S. BROADWAY, 2nd Floor | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY 301 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 14 S. BROADWAY | | | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) 90 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) LITHUANIA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME ISRAEL MINDEL | | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MISS SOPHIE FLEXER, 1811 S. 5th STREET, PHILADELPHIA, PA. 19148 | | | |
| 18. 440.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Cause of Death (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Embolism (B) Antecedent Causes Atherosclerosis, Arteriosclerosis (C) Underlying Condition Arteriosclerosis, Overweight II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 3 stated under (C) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 20 1956 to July 23 1972 , that (I) (we) last saw the deceased alive on 7-21 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Harry Linden M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 7/24/72 | | | |
| 23C. PHYSICIAN'S NAME (Type) HARRY LINDEN | | | | 23D. ADDRESS 14 S. BROADWAY | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 7/26/72 | | 24C. NAME OF CEMETERY or CREMATORY BETH ISRAEL | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Andrew H. Heston | | 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. | | ADDRESS 6010 REISTERSTOWN ROAD | | | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|------------------------------|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | 72 07018 | | 72 07018 | |
| BIRTH NO. | | S-240 | | 72 07018 | |
| 1. NAME OF DECEASED (Type or Print) | | SOKOL, David GREGORY | | 2. DATE AND HOUR OF DEATH 7/25/72 12:30A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY Maryland 2719 | | 5. CITY OR TOWN Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sina Hospital Belvedere Greenspring Ave Baltimore, Maryland, 21115 | | 6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER 3902 PRIMROSE AVE #15 | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 05/20/17 | 9. AGE (In years last birthday) 55 | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) METEOROLOGIST | | 10B. KIND OF BUSINESS OR INDUSTRY BETHLEHEM STEEL | | 11. BIRTHPLACE (State or foreign country) AKRON, OHIO | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME SAMUEL SOKOL | | 14. MOTHER'S MAIDEN NAME ELIZABETH GINSBERG | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. II | | 16. SOCIAL SECURITY NO. 110-03-3640 | | 17. INFORMANT ADDRESS MRS. FLORENCE SOKOL, 3902 PRIMROSE AVENUE #15 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH cerebro-vascular Accident (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs. | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from July 23 19 71 to July 25 19 73 that (I) (we) last saw the deceased alive on July 25 19 73 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE Robert Kneseth, M.D. | |
| 23B. DATE SIGNED 7/25/72 | | 23C. PHYSICIAN'S NAME (Type) Robert Kneseth, M.D. | | 23D. ADDRESS 9009 Meadowheights Rd., Potomac, MD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 7/26/72 | | 24C. NAME of CEMETERY or CREMATORY OHR KNESSETH ISRAEL ANSHE SFARD, ROSEDALE, MARYLAND | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Sidney... | |
| 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | 25D. NAME OF REGISTRAR Sidney... | | 25E. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | |

ALBANY, N.Y.

WESTERN STREET

TELEPHONE

TELEPHONE

TELEPHONE

111-02-2440 JUN. 1940

111-02-2440

111-02-2440 JUN. 1940

72 07019

STATE OF MARYLAND-DHMH
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07019

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Don Cross

2. DATE
OF DEATHKnown ☒ Estimated ☐

Month 7 Day 24 Year 72

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION

113 W. Franklin St.

3. DATE
PRONOUNCED DEAD

Month 7 Day 24 Year 72

Hour 9:35 a.

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

6. SEX

male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. DATE OF BIRTH

1907
Jan. 18, 197210. AGE (In years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

113 W. Franklin Street

11. BIRTHPLACE (State or foreign country)

Indiana

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Elwell L. Cross

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Printer

14B. KIND OF BUSINESS OR INDUSTRY

Printing

15. MOTHER'S MAIDEN NAME

Emma Euth

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

213-03-3791

18. INFORMANT

309 Leyton Road,
Don A. Cross Reisterstown, Md.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/25/72

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

July 28, 1972

24C. NAME of CEMETERY or CREMATORY

Meadowridge Mem. Park Baltimore 27, Md.

24D. LOCATION (City, town, or county) (State)

Baltimore 27, Md.

25A. DATE REC'D BY HEALTH DEPT

JUL 27 1972

25B. NAME OF REGISTRAR

Sidney H. [Signature]

25C. FUNERAL DIRECTOR

H. J. [Signature]

ADDRESS

Owings Mills, Md.

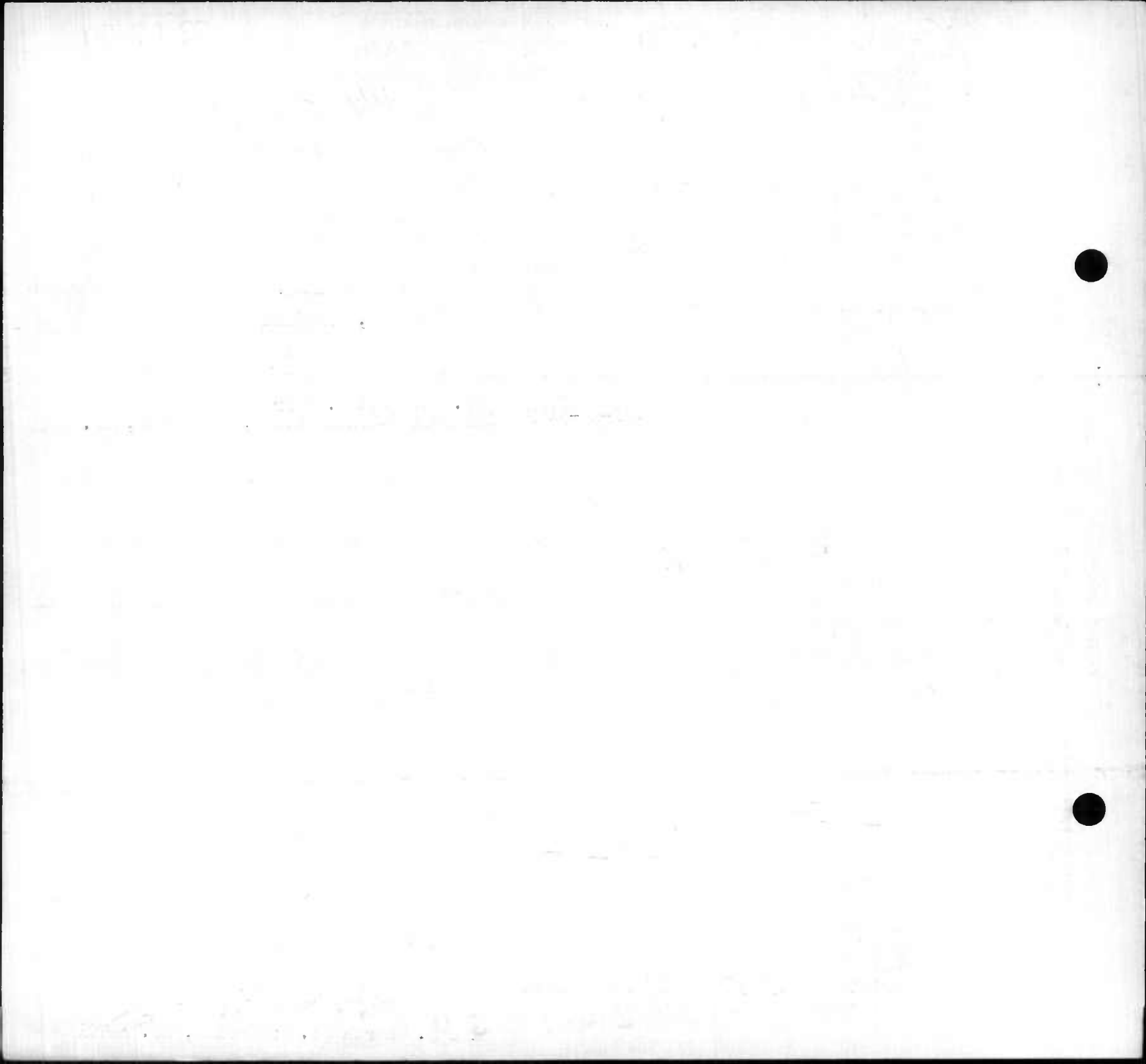
VS 153--SMN

4-11384

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

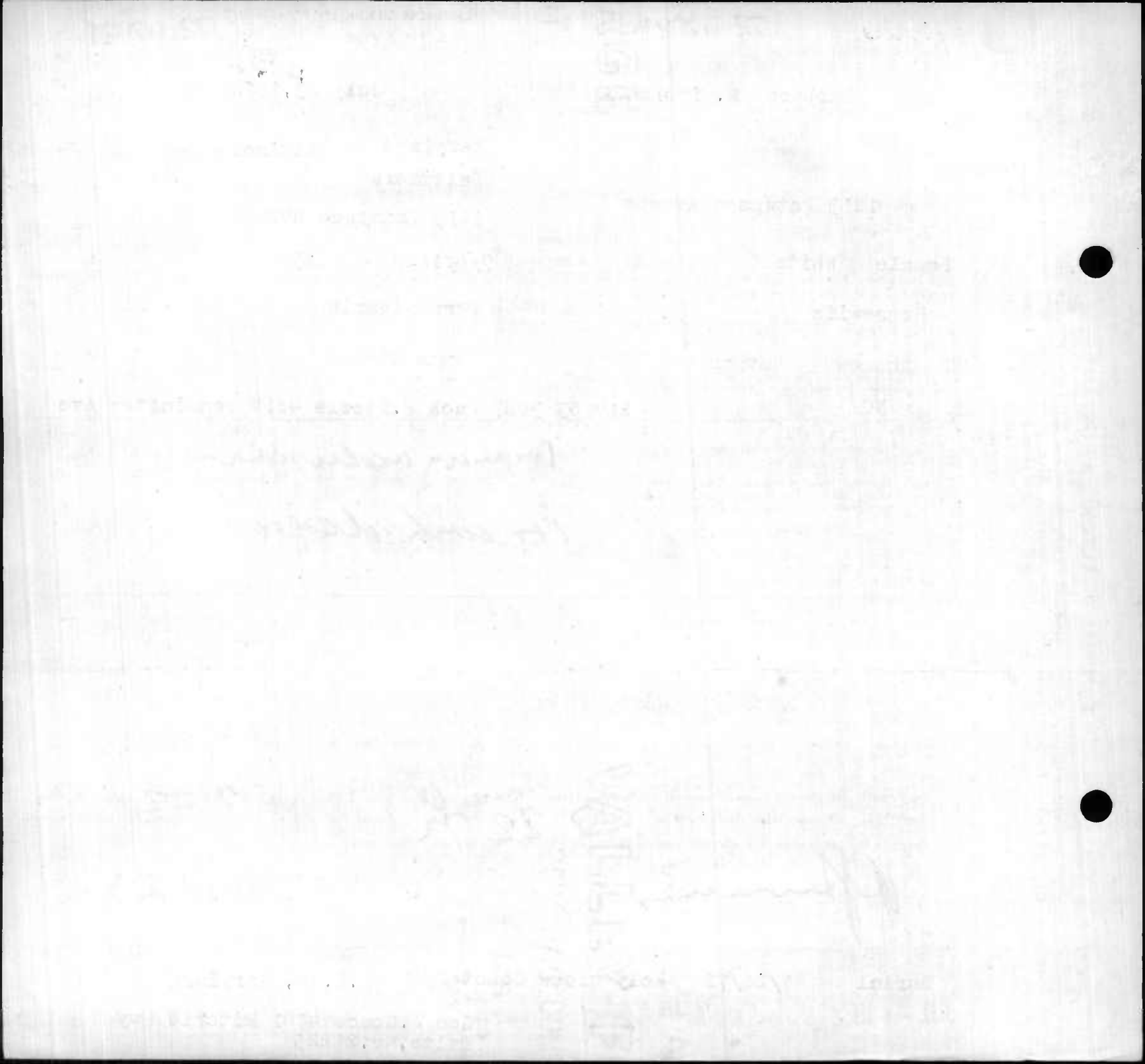
| C-600 | | 72 07020 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | 72 07020 | |
|---|-------------------------|---|------------------------------------|---|---|--|--|
| BIRTH NO. | | 72 07020 | | REG. NO. | | STATE OF MARYLAND-DHMH | |
| 1. NAME OF DECEASED (Type or Print) ARMEY BERNICE CARR | | | | 2. DATE AND HOUR OF DEATH July 25, 1972 15:45 A. M. | | | |
| 3. PLACE IN BALTIMORE/MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Univ. of Maryland Hospital 38 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Frederick Co. C. CITY OR TOWN Frederick D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 224 E. Patrick St. | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/3/18 | 9. AGE (In years last birthday) 53 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian | | 10B. KIND OF BUSINESS OR INDUSTRY Truck Stop O.I. | | 11. BIRTHPLACE (State or foreign country) U.S.A., Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John Carr | | | | 14. MOTHER'S MAIDEN NAME Laura Thomas | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II | | 16. SOCIAL SECURITY NO. 233-14-31149 | | 17. INFORMANT Mrs. Margaret J. Carr 224 East Patrick Street, Frederick, Md. | | | |
| 18. 492X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE Cardiogenic Shock DUE TO, OR AS A CONSEQUENCE OF: (B) Acute Myocardia Infarction DUE TO, OR AS A CONSEQUENCE OF: (C) Emphysema. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 7 days | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (H) (this hospital) attended the deceased from July 22, 1972 to July 25, 1972 that (I) (we) last saw the deceased alive on July 25, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE C. Thomas Folkemer M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED July 25, 1972 | |
| 23C. PHYSICIAN'S NAME (Type) C. Thomas Folkemer M.D. | | | | 23D. ADDRESS Univ. Hosp., Baltimore, Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/27/72 | | 24C. NAME of CEMETERY or CREMATORY Highland Burial Park | | 24D. LOCATION (City, town, or county) (State) Danville, Virginia | |
| 25A. DATE RECEIVED BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Indy Whoddy | | 25C. FUNERAL DIRECTOR'S NAME AND ADDRESS SMITH, FADELEY, KEENEY, BASFORD FUNERAL HOME 906 E. Church St. Frederick, Md. 21701 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

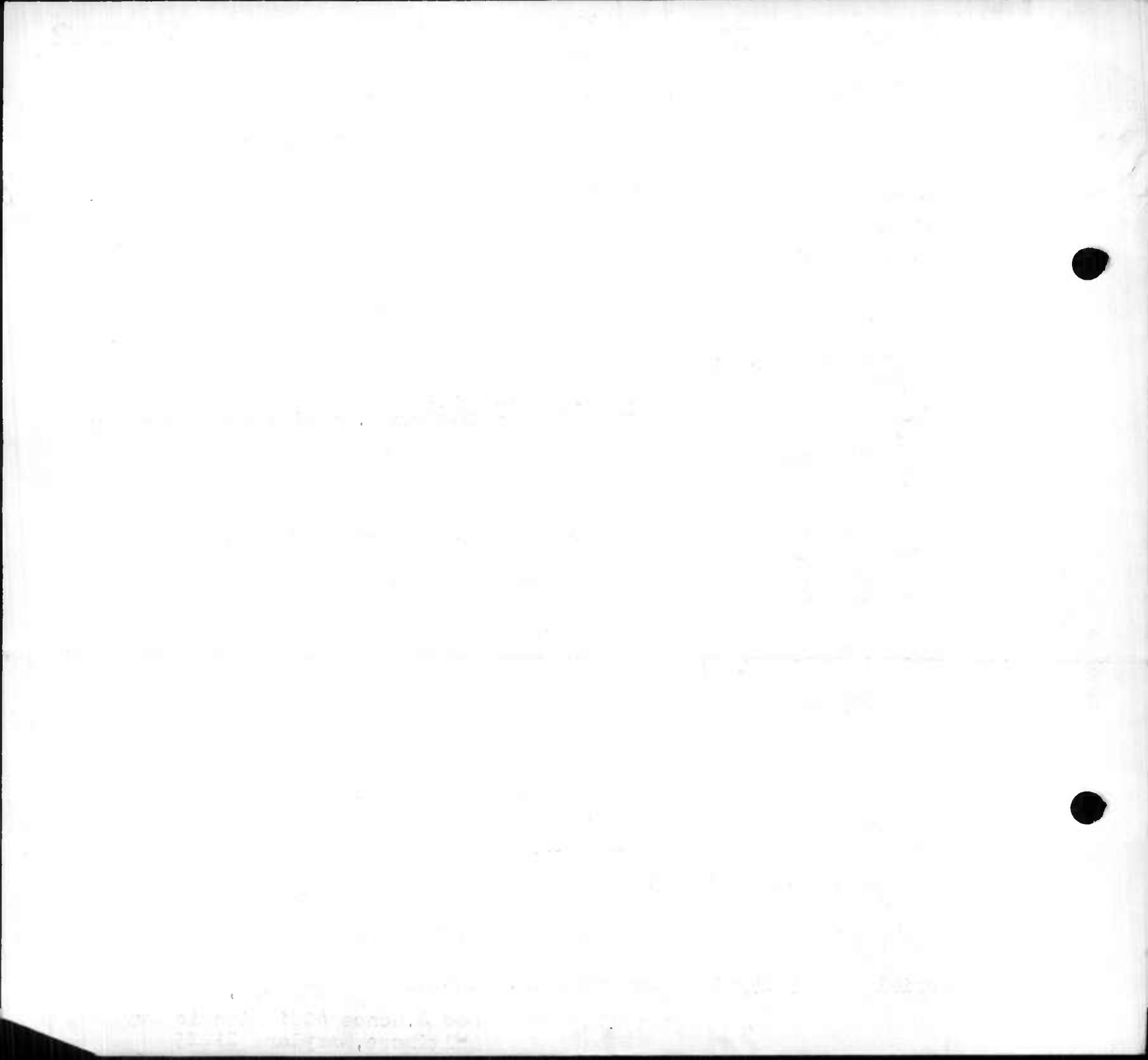
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07021 | | 72 07021 | |
|---|--|--|--|---|--|----------|--|
| BIRTH NO. | | | | REG. NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| Barbara M. Prohaska | | | | July 23, 1972 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | | | |
| 00 1213 Patapsco Avenue | | | | Maryland Baltimore | | | |
| 5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH 9. AGE (In years last birthday) 83 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 11. BIRTHPLACE (State or foreign country) | | | |
| Housewife | | | | Pennsylvania | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Andrew Butner | | | | Anna Stefan | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| NO | | | | 217 03 3087 | | | |
| 17. INFORMANT | | | | ADDRESS | | | |
| NO | | | | Jack B. Steele 4814 Pennington Ave | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE | | | |
| ANTECEDENT CAUSES | | | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | 20A. AUTOPSY? (Yes or No) | | | |
| 19A. DATE OF OPERATION | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED | | | |
| 21F. HOW DID INJURY OCCUR? | | | | 22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | | |
| Burial | | | | 7/26/72 | | | |
| 24C. NAME OF CEMETERY OR CREMATORY | | | | 24D. LOCATION (City, town, or county) (State) | | | |
| Holy Cross Cemetery | | | | A.A.Co, Maryland | | | |
| 25A. NAME OF REGISTRAR | | | | 25B. FUNERAL DIRECTOR | | | |
| Geo J. Gonce | | | | Geo J. Gonce | | | |
| 25C. ADDRESS | | | | 25D. ADDRESS | | | |
| 4001 Ritchie Hwy | | | | Balto, Md. 21225 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | 72 07022 | | 72 07022 | |
| BIRTH NO. | | 72 07022 | | REG. NO. 72 07022 | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | STATE OF MARYLAND-DEHM | |
| McGUIRE JOHN ALBERT | | July 24, 1972 | | 3:25 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | MARYLAND | | Baltimore | |
| SOUTH BALTIMORE GENERAL HOSPITAL | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| BALTIMORE | | BALTIMORE | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER | | 3915 FOURTH STREET | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | |
| MALE | | WHITE | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH | | 9. AGE (In years) | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 7-12-1914 | | 58 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| JUDGE | | | | BALTIMORE | |
| 12. CITIZEN OF WHAT COUNTRY? | | USA | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| FRANK McGuire | | CATHERINE HALLIGAN | | | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| NO | | 218 10 0093 | | Catherine McGuire | |
| 18. CAUSE OF DEATH | | ADDRESS | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | 3915 Fourth St | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES | | 14 hrs. 25 min. | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE | | | |
| CEREBRO-VASCULAR ACCIDENT | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (B) ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) HYPERTENSION | | 6 YEARS | | | |
| II | | 5 YEARS | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | DIABETES MELLITUS | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (X) (this hospital) attended the deceased from 7-23-1972 - 3:40 PM to 7-24-1972 | | | | | |
| that (I) last saw the deceased alive on 7-24-1972 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) | |
| July Iosheff, M.D. | | 23D. ADDRESS | | 23E. FUNERAL DIRECTOR | |
| JULIUS G. TOSHEFF, M.D. | | 2085-Woodbourne Ave, BALTIMORE, MD 21239 | | 4001 Ritchie Hwy | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 7/27/72 | | New Cathedral Cemetery | |
| 24D. LOCATION (City, town, or county) (State) | | Baltimore, Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JUL 27 1972 | | Geo J. Gonce | | 4001 Ritchie Hwy | |
| 25D. ADDRESS | | Baltimore, Maryland 21225 | | | |



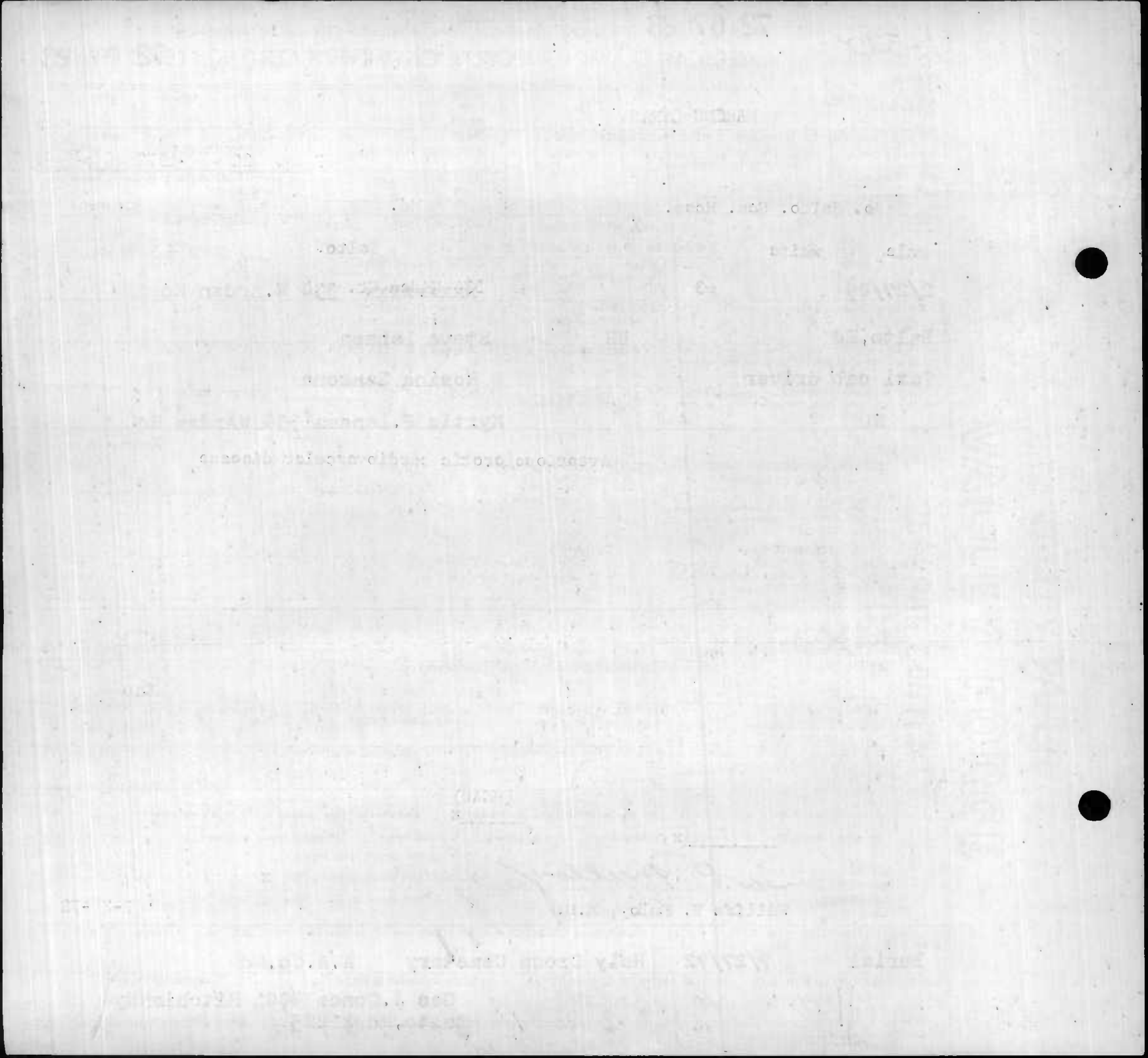
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07023

BIRTH NO.

| | | | |
|---|---|---|--|
| 1. NAME OF DECEASED (Type or Print) MARCUS LANASA | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 43 So. Balto. Gen. Hosp. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour M. 7 22 1972 6 p | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY AA 5200 | | C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 6. SEX male | 7. RACE white | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH 2/27/09 | 10. AGE (In years last birthday) 63 | 11. BIRTHPLACE (State or foreign country) Balto, Md | |
| 12. CITIZEN OF WHAT COUNTRY? US | | 13. FATHER'S NAME Steve Lanasa | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi cab driver | | 14B. KIND OF BUSINESS OR INDUSTRY 334 W. Arden Rd | |
| 15. MOTHER'S MAIDEN NAME Rosina Sansone | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT ADDRESS Myrtle P. Lanasa 334 Warden Rd | |
| 19. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) HEAD | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE W P Mulloy M.D. EXAMINER'S NAME (Type) William P. Mulloy, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-24-72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/27/72 | |
| 24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery | | 24D. LOCATION (City, town, or county) (State) A.A.Co.Md | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Aidway Johnson | |
| 25C. FUNERAL DIRECTOR Geo J. Gonce | | 25D. ADDRESS 4001 Ritchie Hwy Baltimore, Md 21225 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07024 | |
|--|-------------------------|---|------------------------------------|--|---|
| W-415 72 07024 | | | | STATE OF MARYLAND-DEMB | |
| BIRTH NO. | | | | DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Olden H. Wilfong Sr. | | | | 2. DATE AND HOUR OF DEATH 7/24/72 1:55 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Agnes Hospital Baltimore, Maryland | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1902 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 36 S. Carey Street | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/22/88 | 9. AGE (In years last birthday) 84 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) West Virginia | |
| 13. FATHER'S NAME Not Known | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 236-03-3871 | | 17. INFORMANT Son: 1959 Church Road Mr. Olden H. Wilfong, Jr. Dundalk, Md. 21222 | |
| 18. 427.0 + 185X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE PULMONARY EDEMA DUE TO, OR AS A CONSEQUENCE OF: (B) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF: (C) CONGESTIVE HEART FAILURE II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ATRIAL FIBRILLATION, CARCINOMA PROSTATE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 HRS. UNKNOWN UNKNOWN | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) --- | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? --- | |
| 22. I certify that (I) (this hospital) attended the deceased from 12:10 AM 7/24 19 72 to 1:55 AM 7/24 19 72 , that (I) (we) last saw the deceased alive on JULY 24 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert W. Ashmore MD | | | | 23B. DATE SIGNED 7/24/72 | |
| 23C. PHYSICIAN'S NAME (Type) Robert W. Ashmore | | | | 23D. ADDRESS St. Agnes Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation | | 24B. DATE 7-26-72 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park Crematory | |
| 24D. LOCATION Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | | |
| 25B. NAME OF REGISTRAR John J. Duda | | 25C. FUNERAL DIRECTOR ADDRESS 7922 Wise Ave. Dundalk, Md. 21222 | | | |

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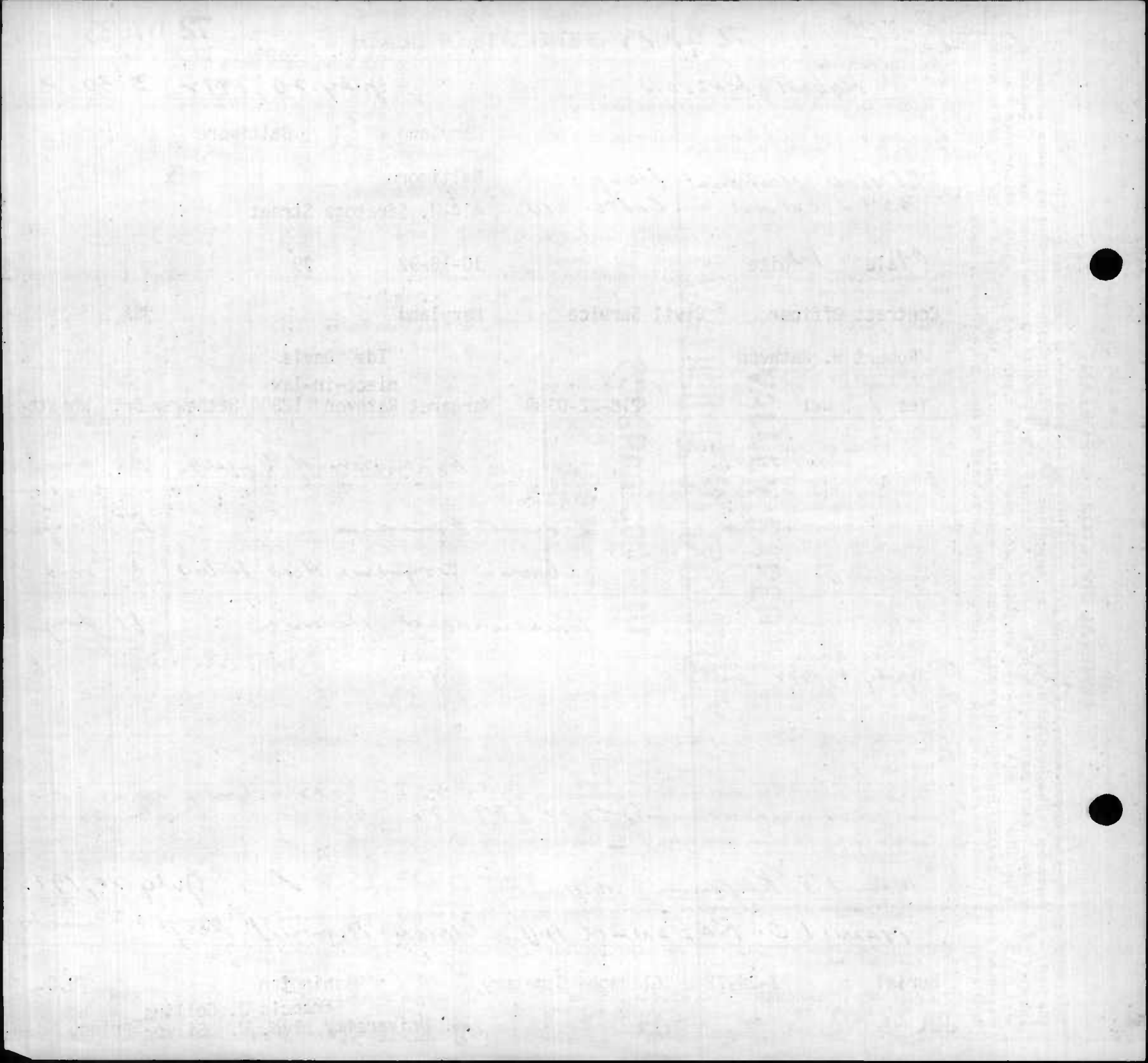
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07025 |
|--|-----------------------------|--|---|---|
| 72 07025 CERTIFICATE OF DEATH | | | | STATE OF MARYLAND-DEMH |
| BIRTH NO. R-315 | | 1. NAME OF DECEASED (Type or Print) ROBERT H. RATHVON | | |
| 2. DATE AND HOUR OF DEATH July 20, 1972 3:30 P M. | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hosp. 4334 + Calvert St. Balto. MD. | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | 5. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 414 W. Saratoga Street | | |
| 6. SEX Male | 7. RACE White | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. DATE OF BIRTH 10-18-92 | 10. AGE (In years last birthday) 79 |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contract Officer | | 12. KIND OF BUSINESS OR INDUSTRY Civil Service | | 13. BIRTHPLACE (State or foreign country) Maryland |
| 14. FATHER'S NAME Robert H. Rathvon | | 15. MOTHER'S MAIDEN NAME Ida Davis | | |
| 16. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI | | 17. SOCIAL SECURITY NO. 218-22-0388 | | 18. INFORMANT niece-in-law Margaret Rathvon 12804 Hathaway Dr. Wheaton |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Aspiration of Mucous ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute Pneumonia Chronic congestive Heart Failure Incarcerated Hernia | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min. 5 days 1 mo. 11 days |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | |
| 21A. DATE OF OPERATION 3 July 9, 1972 | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED 3 in. | | 22A. AUTOPSY? (Yes or No) Yes |
| 21C. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21E. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21F. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21G. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21H. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from July 9, 1972 to July 20, 1972 , that (I) (we) last saw the deceased alive on July 20 8 AM, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE Manuel O. Rafanan M.D. | | | | 23B. DATE SIGNED July 20, 1972 |
| 23C. PHYSICIAN'S NAME (Type) MANUEL O. RAFANAN M.D. | | 23D. ADDRESS Union Memorial Hosp. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 7-24-72 | 24C. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery | 24D. LOCATION (City, town, or county) (State) Washington D.C. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Francis J. Collins | | 25C. FUNERAL DIRECTOR ADDRESS 500 University Blvd., W. Silver Spring, Md. |



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

James A. Krieger

2. DATE AND HOUR OF DEATH

7/23/72 10:21 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)4940 Eastern Avenue Baltimore, Maryland
BALTIMORE CITY HOSPITAL 212244. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

BALTIMORE

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

511 McClinton St 21205

5. SEX

6. RACE

Male Caucasian

7. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

12/8/62

9. AGE (in years
lost birthday)

69

10. Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Mechanics helper

10B. KIND OF BUSINESS OR INDUSTRY

Balto. City

11. BIRTHPLACE (State or foreign country)

BALT. MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Krieger

14. MOTHER'S MAIDEN NAME

Rosalee Kido

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.
214-03-1039 A

17. INFORMANT

4940 Eastern Avenue

BCH: RECORDS

Baltimore, Maryland 21224

18. 593.2 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) Notating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

Renal Failure

IMMEDIATE CAUSE

Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF:

Hypertension (Heat Stroke)

DUE TO, OR AS A CONSEQUENCE OF:

(c) Hypertension Temp 109°

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

4 hours

4 day

4 hrs

8 hrs

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/23 1972 to 7/23 1972
that (I) (we) last saw the deceased alive on 7/23/72 1972 and that (in my) (our) opinion death occurred on the date
and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Richard L. Sylvan M.D.

DEGREE

Attending ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

7/23/72

23C. PHYSICIAN'S
NAME (Type)

Richard L. Sylvan, M.D.

DEGREE

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7/27/72

24C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cemetery

24D. LOCATION

(City, town, or county)

Balto. Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 27 1972

25B. NAME OF REGISTRAR

Audrey W. Winton

25C. FUNERAL DIRECTOR

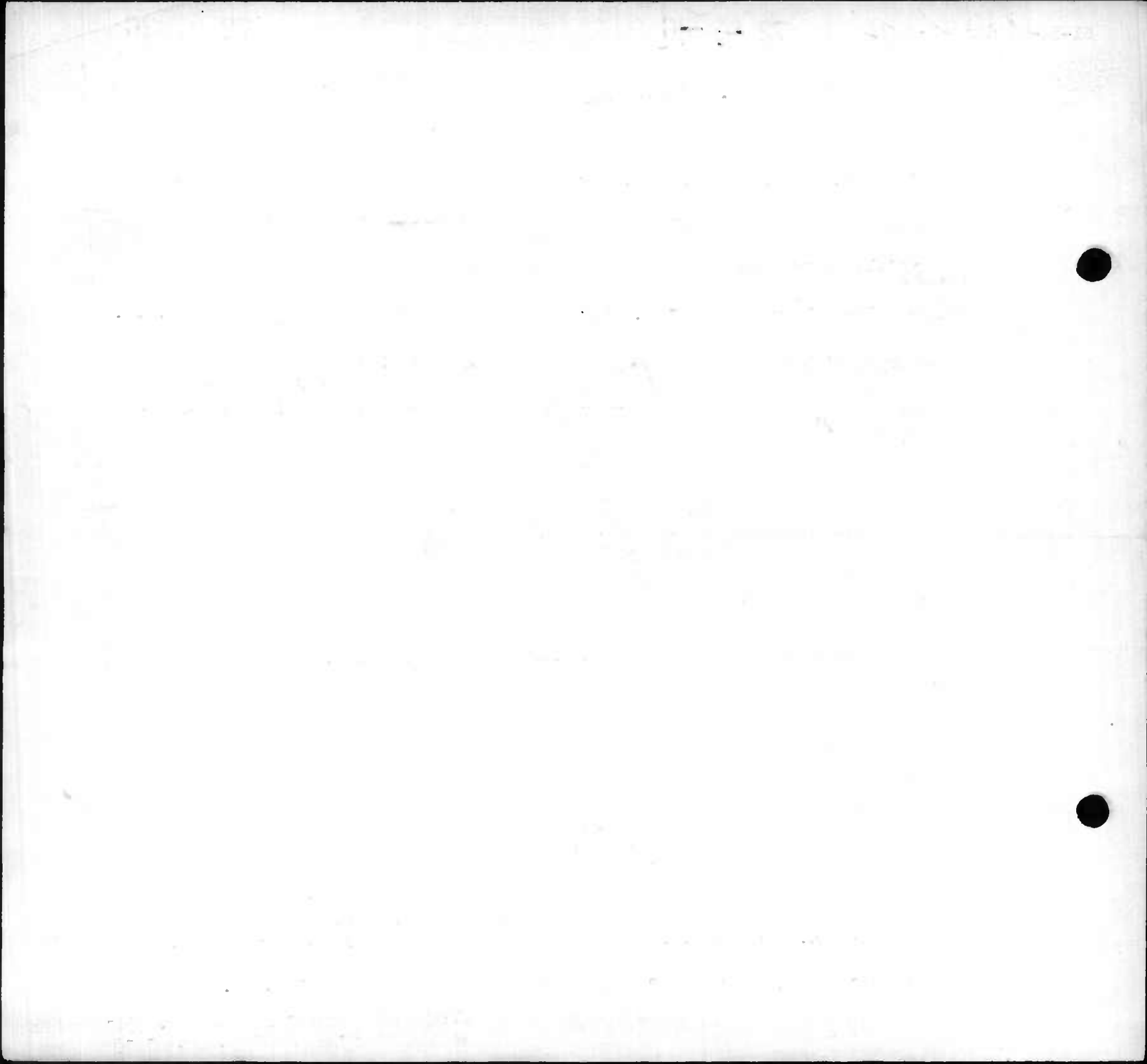
Schunck Funeral Homes, Inc. 3331 Brehms

ADDRESS

Tano, Balto. Md. 21213

FUNERAL DIRECTOR: IMPORTANT

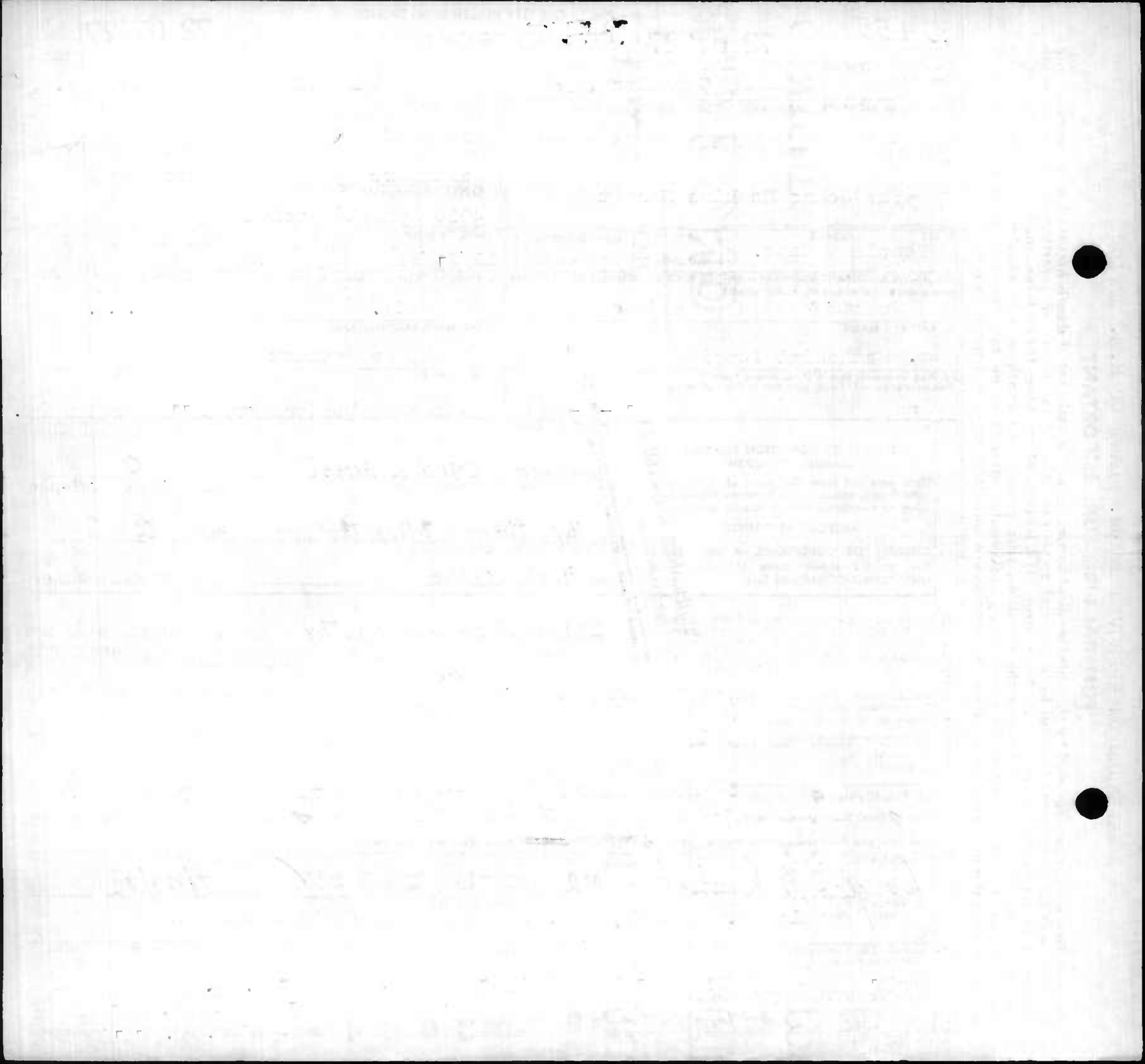
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|------------------|---|------------------------------|---|-----------------------------|--|--|
| B-655 | | 72 07027 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07027 | |
| BIRTH NO. | | 72 07027 | | CERTIFICATE OF DEATH | | STATE OF MARYLAND - DHMH | |
| 1. NAME OF DECEASED (Type or Print) BORMAN, Cornelia Jane | | | | 2. DATE AND HOUR OF DEATH 7/23/72 | | 9:30 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 The Johns Hopkins Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4036 Lyndale Avenue | | | |
| 5. SEX Female | 6. RACE Cauc. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/21/92 | 9. AGE (In years last birthday) 79 | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY at home | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Wm. Nathaniel Topping | | | | 14. MOTHER'S MAIDEN NAME Olivia Bennett | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. 215-42-7869 | | 17. INFORMANT James Topping (brother) 3617 Edmondson Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEAT STROKE CARDIAC ARREST HYPER THERMIA + HYPOTHERMIA HEAT STROKE CONSUMPTION COAGULOPATHY | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hyper hours - unknown hypo 60 min hours - unknown hours - unknown | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A) | | | | | | | |
| 21A. DATE OF OPERATION 2 | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21C. AUTOPSY? (Yes or No) Yes | | 21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 00-00 | | | |
| 21D. TIME OF INJURY (APPROX.) 1 Month () Day () Year () Hour () | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (this hospital) attended the deceased from 7-23 19 72 to 7-23 19 72 that (we) last saw the deceased alive on 7-23 19 72 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death. | | | | | | | |
| 23A. SIGNATURE Douglas J. Deutsch MD | | | | 23B. DATE SIGNED 7/23/72 | | | |
| 23C. PHYSICIAN'S NAME (Type) Douglas J. Deutsch, M.D. | | | | 23D. ADDRESS The Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 7/27/72 | | 24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Audrey Ingham | | 25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. | | ADDRESS 3331 Brehms Lane, Balto. Md. 21213 | |



BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Steve P. Balko

2. DATE OF DEATH

Known ☐ Estimated ☐

Month 7 Day 21 Year 72 Hour 8.42 P.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

00 5138 Wright Avenue

3. DATE PRONOUNCED DEAD

Month 7 Day 21 Year 72 Hour 8:42 p.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Md.

B. COUNTY 2634

6. SEX

male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

7 16 1892

10. AGE (In years lost birthday)

80

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

5136 Wright Avenue

11. BIRTHPLACE (State or foreign country)

Czech.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Coal Miner

14B. KIND OF BUSINESS OR INDUSTRY

Unknown

15. MOTHER'S MAIDEN NAME

Unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)

NO

17. SOCIAL SECURITY NO.

191 81 8910

18. INFORMANT

Andrew Balko

ADDRESS

5138 Wright Ave.

19. 412.4 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒

DATE SIGNED

7/22/72

EXAMINER'S NAME (Type)

Charles S. Springate, M.D.

ASSOCIATE MEDICAL EXAMINER ☐

24A. BURIAL CREMATION, REMOVAL OR DISPOSAL

Remove

24B. DATE

1 7-22-72

24C. NAME OF CEMETERY or CREMATORY

St. Marys

24D. LOCATION (City, town, or county)

Brownsville, Pa.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 27 1972

25B. NAME OF REGISTRAR

Lidger...

25C. FUNERAL DIRECTOR

ADDRESS

Schimunek Funeral Home

3331 Brehms Lane Balto. Md. 21213

1957-1958

1957-1958

1957-1958

WALTON COUNTY

P-200

72 07029

STATE OF MARYLAND - DEPT.
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07029

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) JOSEPH/POSEY | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2941 Erdman Ave. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour M. July 23, 1972 10 p | |
| 6. SEX male | | 7. RACE white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 9/7/94 | | 10. AGE (In years last birthday) 77 | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? - | |
| 13. FATHER'S NAME Joseph Posey | | 14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 831 | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) tire builder | | 14B. KIND OF BUSINESS OR INDUSTRY Schenuit Tire Co. | |
| 15. MOTHER'S MAIDEN NAME Anna Emge | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | |
| 17. SOCIAL SECURITY NO. 215-07-5055 | | 18. INFORMANT ADDRESS James Posey (brother) 2339 Searles Rd. | |
| 19. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) no | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Noturol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 24, 1972 ACTUAL SIGNATURE Marvin S. Platt M.D. EXAMINER'S NAME (Type) Marvin S. Platt, MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/27/72 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt. Maria Cemetery | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Adrienne Whorton | |
| 25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213 | | ADDRESS | |

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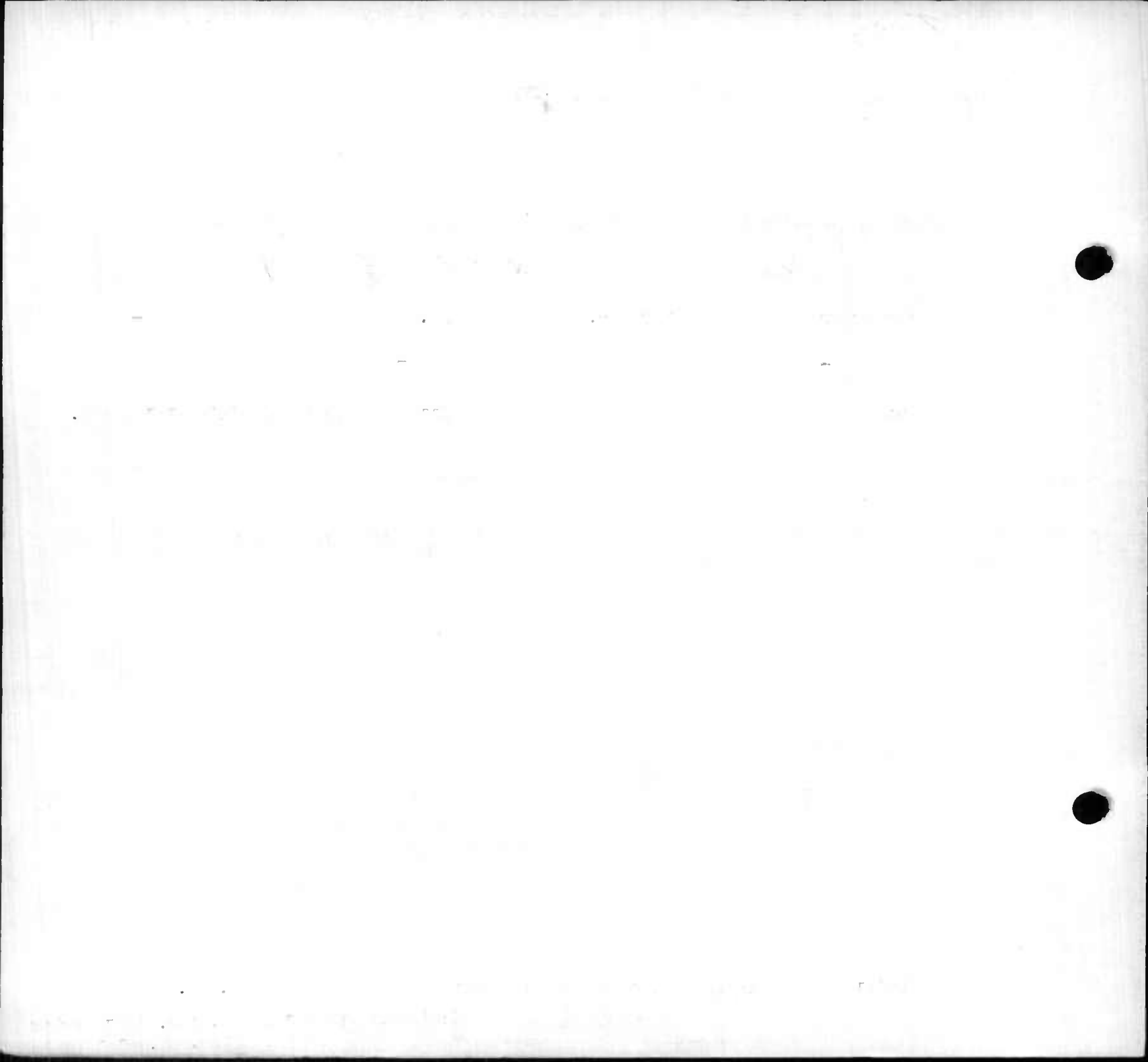
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1950 37

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

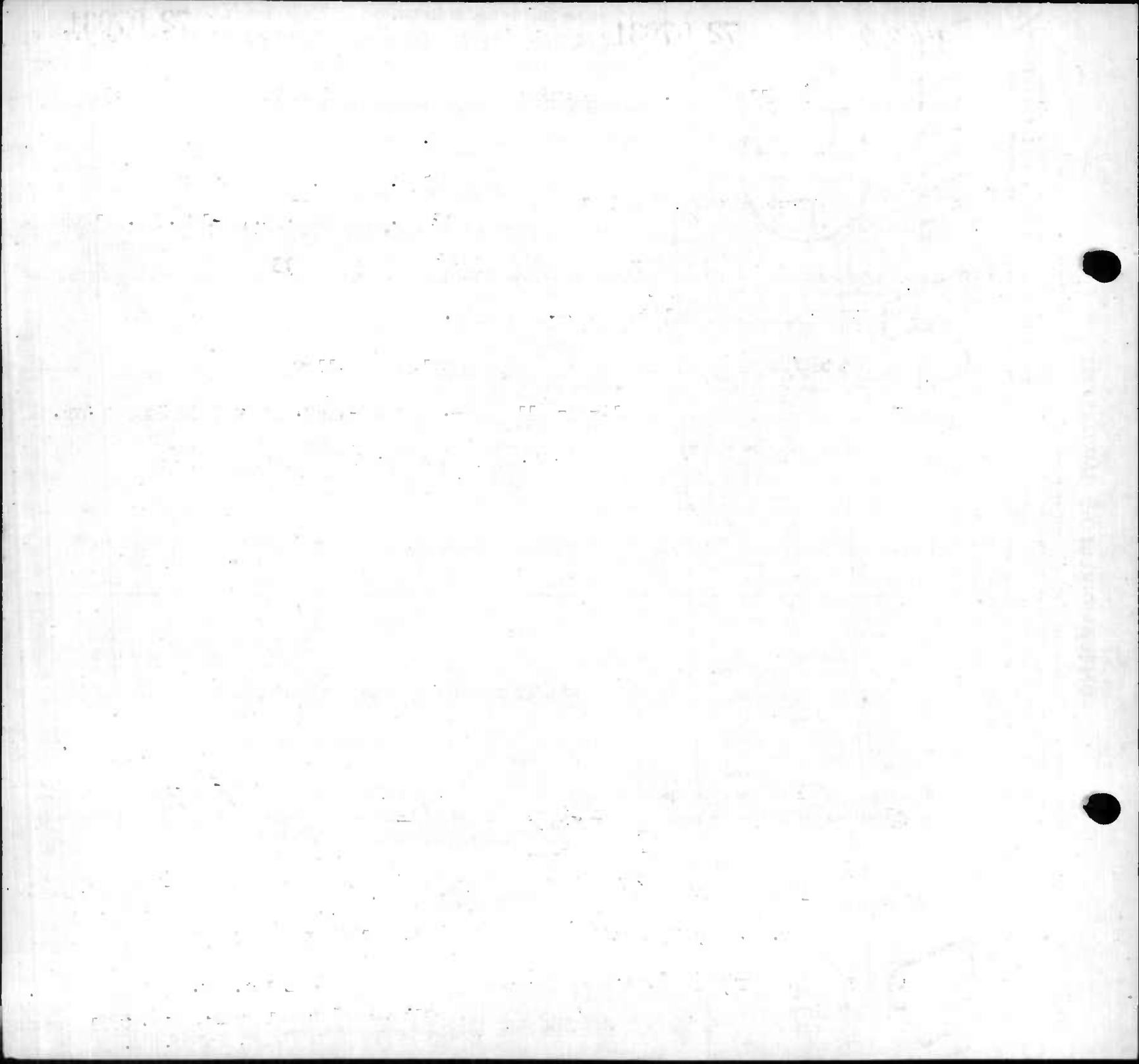
| Z-220 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07030 | |
|--|--|--|--|---|--|
| 72 07030 | | CERTIFICATE OF DEATH | | STATE OF MARYLAND-DHMH | |
| 1. NAME OF DECEASED (Type or Print) ZUKAS, GLADYS, ESTELLA | | 2. DATE AND HOUR OF DEATH 7-24-72 9³⁰ A M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BON SECOURS Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2643 | | | |
| 5. SEX F | | 6. RACE N | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 8. DATE OF BIRTH 01/24/05 | | 9. AGE (In years last birthday) 67 | | 10. UNDER 1 Yr. Months: Days: 11. UNDER 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector | | 10B. KIND OF BUSINESS OR INDUSTRY Koppers Co. | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 12. CITIZEN OF WHAT COUNTRY? - | | 13. FATHER'S NAME - | | | |
| 14. MOTHER'S MAIDEN NAME - | | 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | |
| 16. SOCIAL SECURITY NO. - | | 17. INFORMANT William Zukas (son) ADDRESS 3646 Elmley Ave. | | | |
| 18. 156-0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Cardio-pulmonary failure DUE TO, OR AS A CONSEQUENCE OF: (B) Carcinoma of Gall Bladder with metastasis to liver DUE TO, OR AS A CONSEQUENCE OF: (C) - APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min. 1 year 12 | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | 20A. AUTOPSY? (Yes or No) - | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) - | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) - | |
| 21D. TIME OF INJURY (APPROX.) 1 Month) 1 Day) 1 Year) 1 Hour) - | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? - | |
| 22. I certify that (I) (this hospital) attended the deceased from 06/03 19 72 to 7-24 19 72 that (I) (we) last saw the deceased alive on 7-24 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE S. Somchit Vamvanit | | 23B. DATE SIGNED July 24, 1972 | | 23C. PHYSICIAN'S NAME (Type) Dr. SOMCHIT VAMVANIT | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/27/72 | | 24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery | |
| 24D. LOCATION Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Schirunok | |
| 25C. FUNERAL DIRECTOR Schirunok Funeral Homes, Inc. | | 25D. ADDRESS 3331 Brehms Lane, Balto. Md. 21213 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

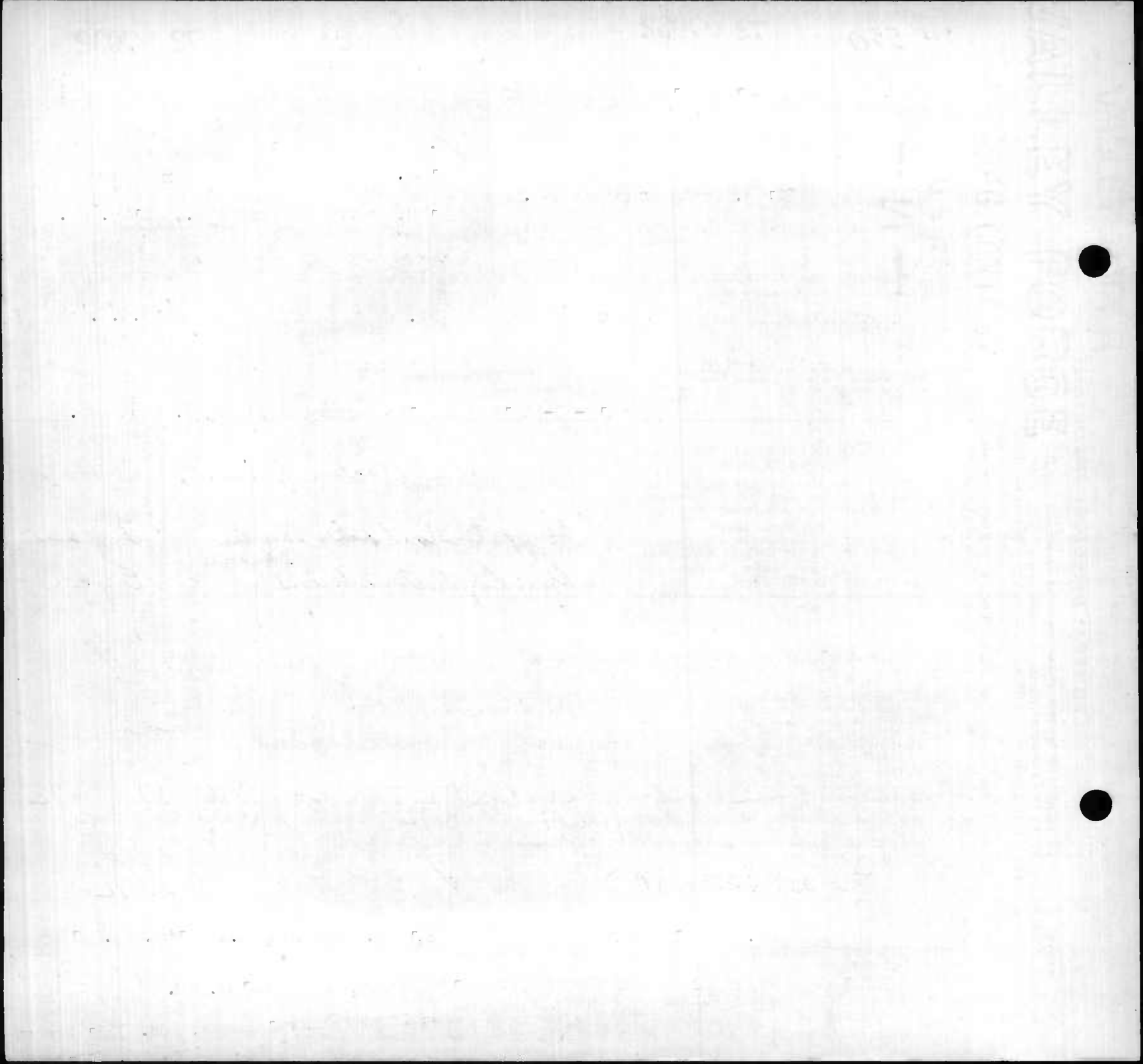
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07031 | | 72 07031 | |
|--|--|---|--|--|--|--|--|
| BIRTH NO. M-210 | | | | REG. NO. 72 07031 | | STATE OF MARYLAND-DEMD | |
| 1. NAME OF DECEASED (Type or Print) Ella F. Mackabee | | | | 2. DATE AND HOUR OF DEATH 7/22/72 7:30 M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 Church Home and Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 702 | | | |
| 5. SEX F | | 6. RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3/2/99 73 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress | | 10B. KIND OF BUSINESS OR INDUSTRY Earlanger & Co. | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John Zink | | | | 14. MOTHER'S MAIDEN NAME Charlotte Noeller | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 217-09-7911 | | 17. INFORMANT ADDRESS Wm. Mackabee, Jr. (son) 3939 Kenyon Ave. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH Acute Myocardial Infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from July 24 1956 to 7/27 1972 , that (1) (we) last saw the deceased alive on 6/27 1972 and that it is (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE W. M. Meredith Smith | | | | 23B. DATE SIGNED 7/24/72 | | | |
| 23C. PHYSICIAN'S NAME (Type) Dr. W. Meredith Smith | | 23D. ADDRESS 6305 Alameda | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 7/26/72 | | 24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Sidney Johnston | | 25C. FUNERAL DIRECTOR Schimmek Funeral Homes, Inc. | | ADDRESS 3331 Brehms Lane, Balto. Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

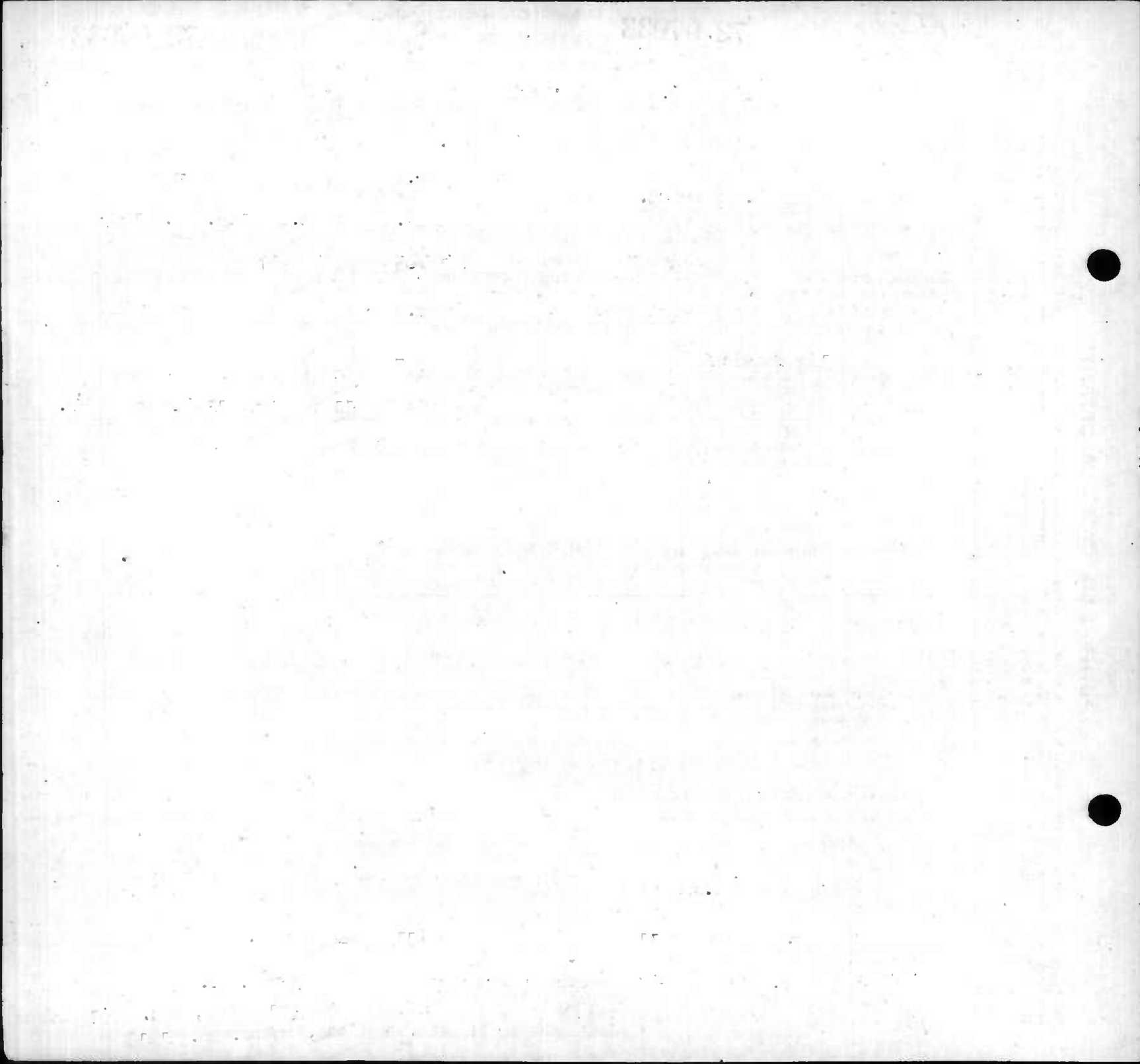
| BIRTH NO. <u>H-550</u> | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | STATE OF MARYLAND-DEPT. OF HEALTH | | | |
|--|--|---------------------|--|--|--|--|--|--|--|---|--|
| 72 07032 | | | | REG. NO. 72 07032 | | | | 72 07032 | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Mabel (Mable) Marie Haman</u> | | | | 2. DATE AND HOUR OF DEATH <u>7/23/72</u> <u>1 P</u> M. | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>603</u> | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00</u> <u>221 N. Patterson Park Ave.</u> | | | | C. CITY OR TOWN <u>Balto.</u> | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | E. STREET AND NUMBER <u>221 N. Patterson Park Ave., Balto. Md.</u> | | | | | | | |
| 5. SEX <u>F</u> | | 6. RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>7/23/72</u> <u>68</u> | | 9. AGE (In years (last birthday)) <u>68</u> | | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | 13. FATHER'S NAME <u>Morris Parrish</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Anna McDay</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | | | 16. SOCIAL SECURITY NO. <u>219-03-4281</u> | | | | 17. INFORMANT <u>Charles Haman (son)</u> ADDRESS <u>273 S. East Ave.</u> | | | |
| 18. <u>4/2-2 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Cardiac Failure</u> (B) <u>Hypertensive Cardio-Vascular Disease</u> (C) <u>Generalized Atherosclerosis</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hours</u> <u>2 years</u> <u>5 years</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>April 1</u> 19 <u>69</u> to <u>July 17</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>July 17</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <u>Israel Rosen M.D.</u> | | | | | | | | 23B. DATE SIGNED <u>7/25/72</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Dr. Israel Rosen</u> | | | | | | | | 23D. ADDRESS <u>2413 E. Monument St., Balto. Md. 21205</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | 24B. DATE <u>7/25/72</u> | | | | 24C. NAME of CEMETERY or CREMATORY <u>Baltimore National Cemetery</u> | | | |
| 24D. LOCATION <u>Balto. Md.</u> | | | | 24E. FUNERAL DIRECTOR <u>Scimmek Funeral Homes, Inc.</u> | | | | 24F. ADDRESS <u>3331 Broome Lane, Balto. Md. 21205</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 27 1972</u> | | | | 25B. NAME OF REGISTRAR <u>Lidney</u> | | | | 25C. FUNERAL DIRECTOR <u>Scimmek Funeral Homes, Inc.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

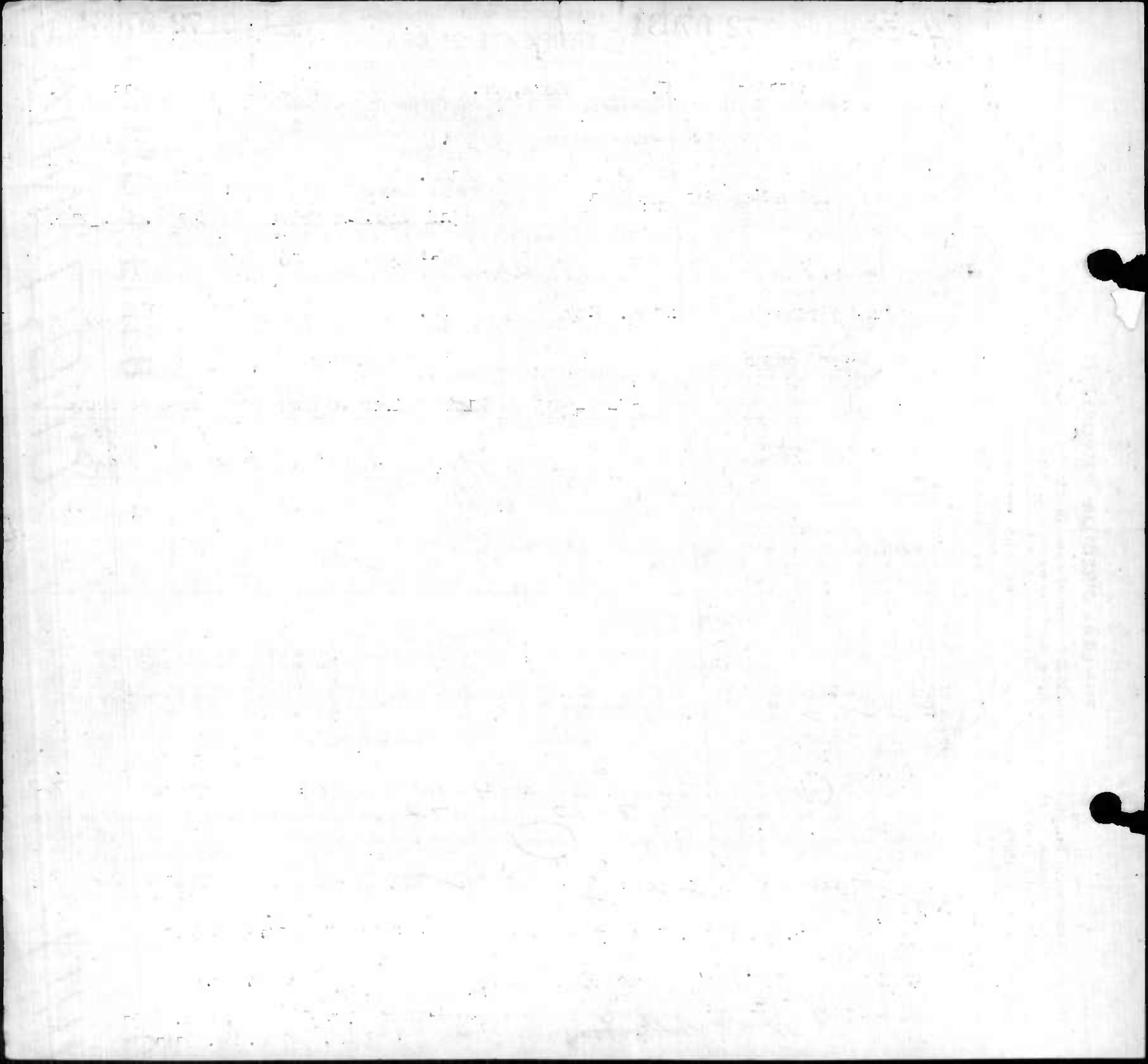
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07033 | |
|--|----------------------------|---|---|---|---|
| 72 07033 | | | | STATE OF MARYLAND - DEPT | |
| BIRTH NO. G-620 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Sophia I. Gorecki | | 2. DATE AND HOUR OF DEATH 7/22/72 1:29 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 2528 E. Eager St. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 702 C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2528 E. Eager St., Balto., Md. 21205 | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/15/05 | 9. AGE (In years last birthday) 67 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10B. KIND OF BUSINESS OR INDUSTRY at home | | 11. BIRTHPLACE (State or foreign country) Penna. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Felix Stawicki | | | |
| 14. MOTHER'S MAIDEN NAME - | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Marie Duval (dghtr) 811 Stagshead Rd. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 250.9 I PULMONARY EDEMA | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: AS - HEART DISEASE | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HOURS | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). STAG HORN RENAL CALCULUS | | (B) DUE TO, OR AS A CONSEQUENCE OF: DIABETES MELLITUS | | 2 YEARS | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: 10 YEARS | | 15 YEARS | | 15 YEARS | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 50 to 19 72, that (I) (we) last saw the deceased alive on 7/17 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert Duval | | 23B. DATE SIGNED 7/24/72 | | 23C. PHYSICIAN'S NAME (Type) Dr. Robert Duval | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 7/25/72 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | | |
| 25B. NAME OF REGISTRAR Shimunek Funeral Homes, Inc. | | 25C. FUNERAL DIRECTOR ADDRESS 3331 Brehms Lane, Balto. Md. 21213 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

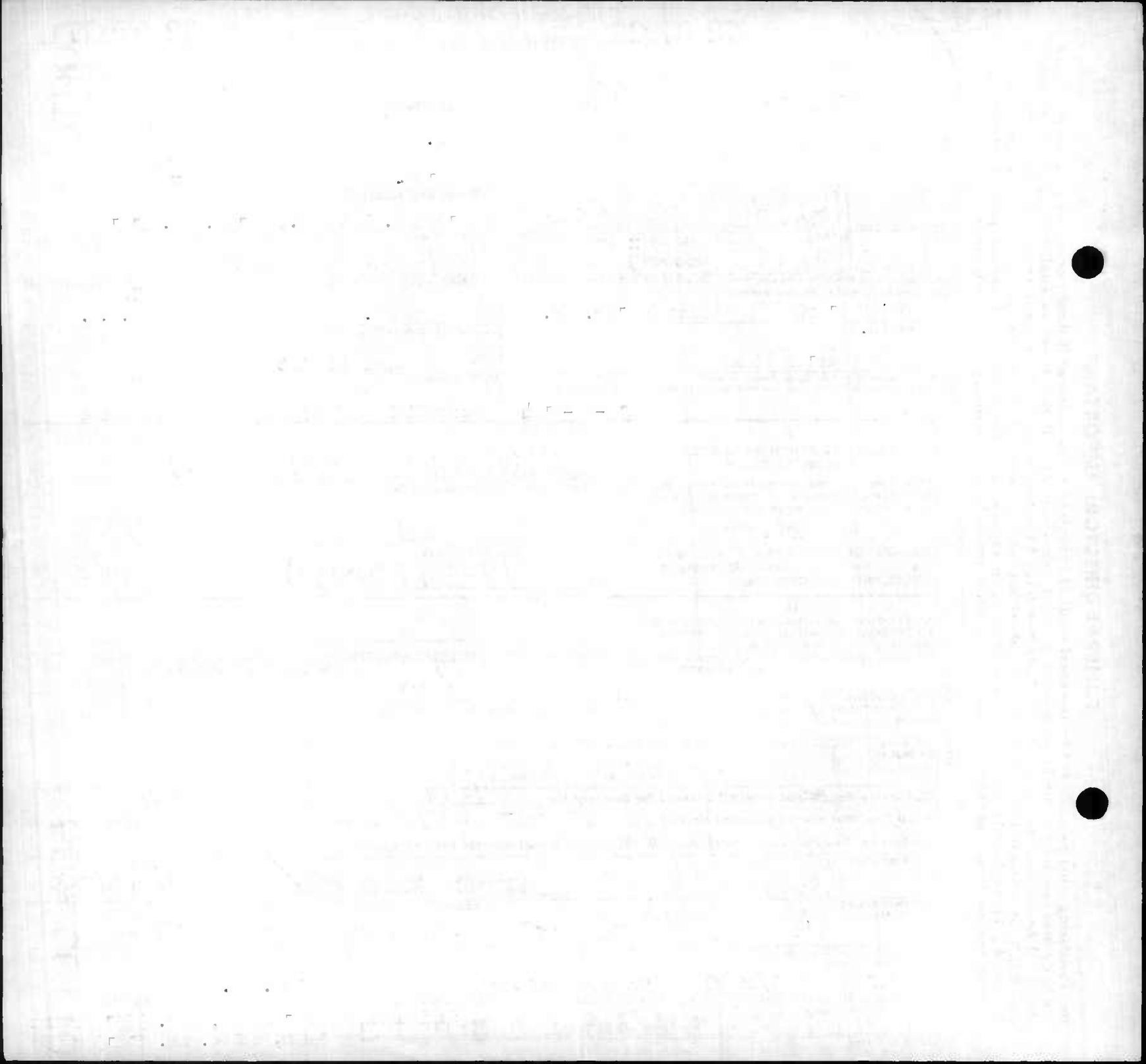
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07034 | | 72 07034 | |
|--|--|--|--|---|--|--|--|
| A-352 | | | | REG. NO. | | STATE OF MARYLAND-DHMH | |
| BIRTH NO. | | | | 7/20/72 | | | |
| 1. NAME OF DECEASED (Type or Print) William G. Adams, Sr. | | | | 2. DATE AND HOUR OF DEATH 7/20/72 11 P. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2642 | | | |
| 5. SEX M 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH 9/18/85 | | 9. AGE (In years last birthday) 86 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Fireman | | | | 10B. KIND OF BUSINESS OR INDUSTRY Balto. City | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 13. FATHER'S NAME Edward Adams | | | | 14. MOTHER'S MAIDEN NAME Mary Mainster | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. 218-26-2534 | | 17. INFORMANT Elsie Weider (dghtr) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, pneumonia, etc. It means the disease, injury or complication which caused death.) 410.9 I CAUSE OF DEATH Myocardial Infarction 1 HR | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-11 1969 to 7-10 1972 , that (I) (we) last saw the deceased alive on 7-10 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Francis X. Carmody DEGREE | | | | | | 23B. DATE SIGNED 7-24-72 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Francis X. Carmody DEGREE | | | | | | 23D. ADDRESS Union Memorial Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 7/24/72 | | 24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Adrian W. K. K. | | 25C. FUNERAL DIRECTOR Schimmels Funeral Homes, Inc. | | ADDRESS 3331 Brehms Lane, Balto. Md. 21213 | |



FUNERAL DIRECTOR: IMPORTANT

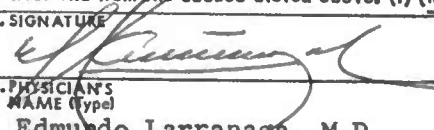
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

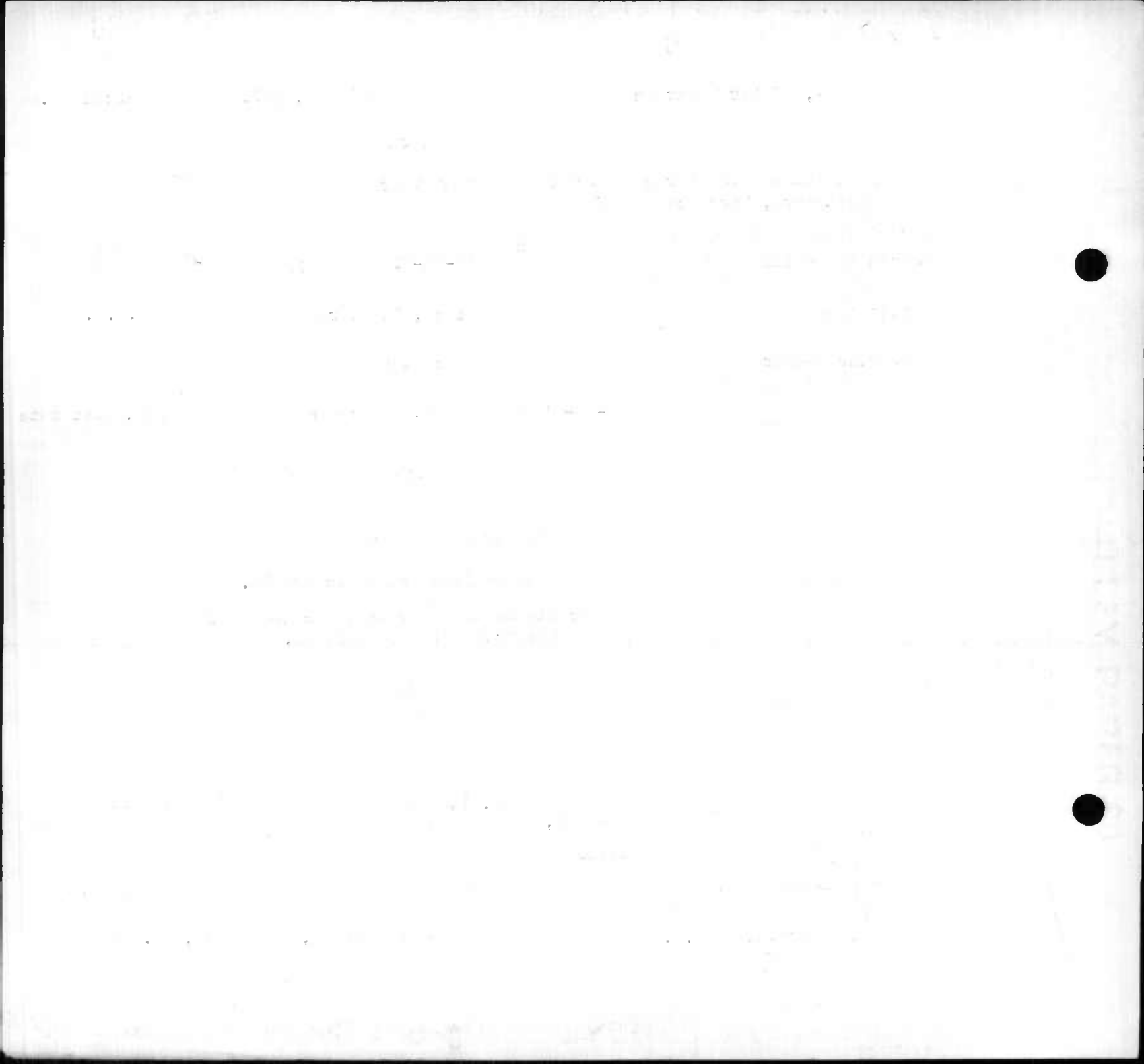
| | | | |
|---|----------------------|---|--------------------------------|
| 1. NAME OF DECEASED (Type or Print) Louis C. Fink | | 2. DATE AND HOUR OF DEATH 7-21-72 11:00 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 902 | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-7-06 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY Gas & Elec. Co. | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Fink | | 14. MOTHER'S MAIDEN NAME Anna Schmidt | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 212-05-7194 | |
| 17. INFORMANT Mary Fink (wife) | | ADDRESS same as above | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE ASCUD (B) DUE TO, OR AS A CONSEQUENCE OF: HYPERTENSION (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YRS YRS | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examined) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that II (this hospital) attended the deceased from 7-14 19 72 to 7-21 19 72 that I (we) last saw the deceased alive on 7-21-72 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) the (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Claudius Klimt | | 23B. DATE SIGNED 7/24/72 | |
| 23C. PHYSICIAN'S NAME (Type) CLAUDIUS KLIMT | | 23D. ADDRESS MERCY HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 7/25/72 | |
| 24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Sidney B. Brehms | |
| 25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. | | ADDRESS 3331 Brehms Lane, Balto. Md. 21213 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

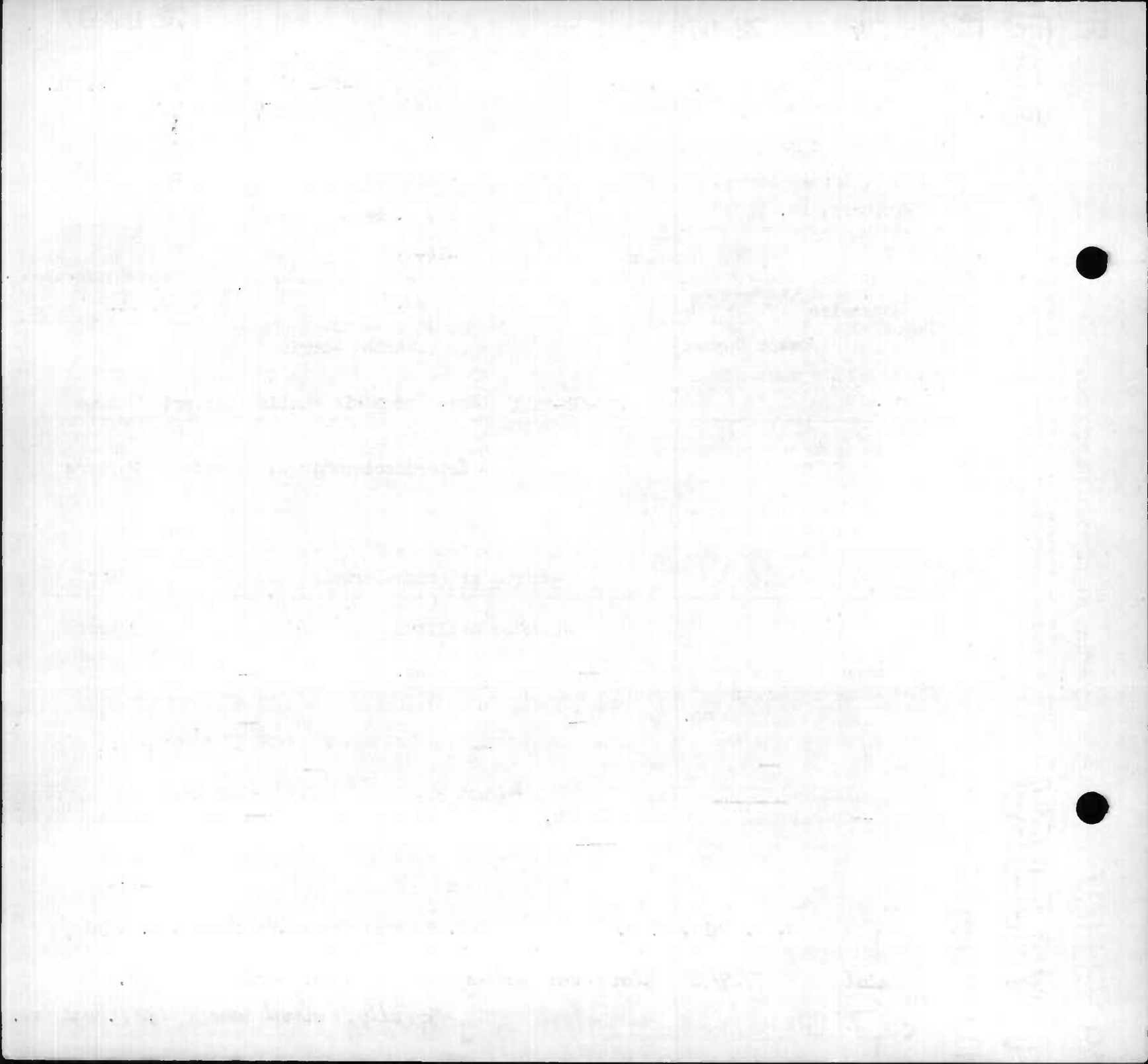
| 7-560 | | 72 07036 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07036 | |
|--|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. STATE OF MARYLAND - DDMH | | | |
| 1. NAME OF DECEASED (Type or Print) FENNER, Sister Gertrude | | | | 2. DATE AND HOUR OF DEATH July 24, 1972 12:35 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 19 The Seton Psychiatric Institute Baltimore, Maryland 21215 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE New York B. COUNTY V29 | | | |
| 5. SEX Female | | 6. RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12-12-93 | |
| 9. AGE (in years last birthday) 78 | | 10. UNDER 1 Yr. Months: Days: Hours: Min. | | 11. BIRTHPLACE (State or foreign country) Utica, New York | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Religious | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | |
| 13. FATHER'S NAME Charles Fenner | | | | 14. MOTHER'S MAIDEN NAME Anna Fahy | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 061-42-0160T | | 17. INFORMANT ADDRESS Hospital Records - The Seton Psych. Institute | |
| 18. CAUSE OF DEATH 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic brain syndrome associated with cerebral arteriosclerosis. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) 1 Month (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb. 7, 1969 to July 24, 1972 that (I) (we) lost saw the deceased alive on July 24, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE  | | | | 23B. DATE SIGNED July 24, 1972 | | 23C. PHYSICIAN'S NAME (Type) Edmundo Larranaga, M.D. | |
| 24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) Burial 7/25/72 | | | | 24C. NAME of CEMETERY or CREMATORY St. Joseph | | 24D. LOCATION (City, town, or county) (State) Emmitsburg Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Lidney | | 25C. FUNERAL DIRECTOR Clarence C. Wilson | | ADDRESS Emmitsburg Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

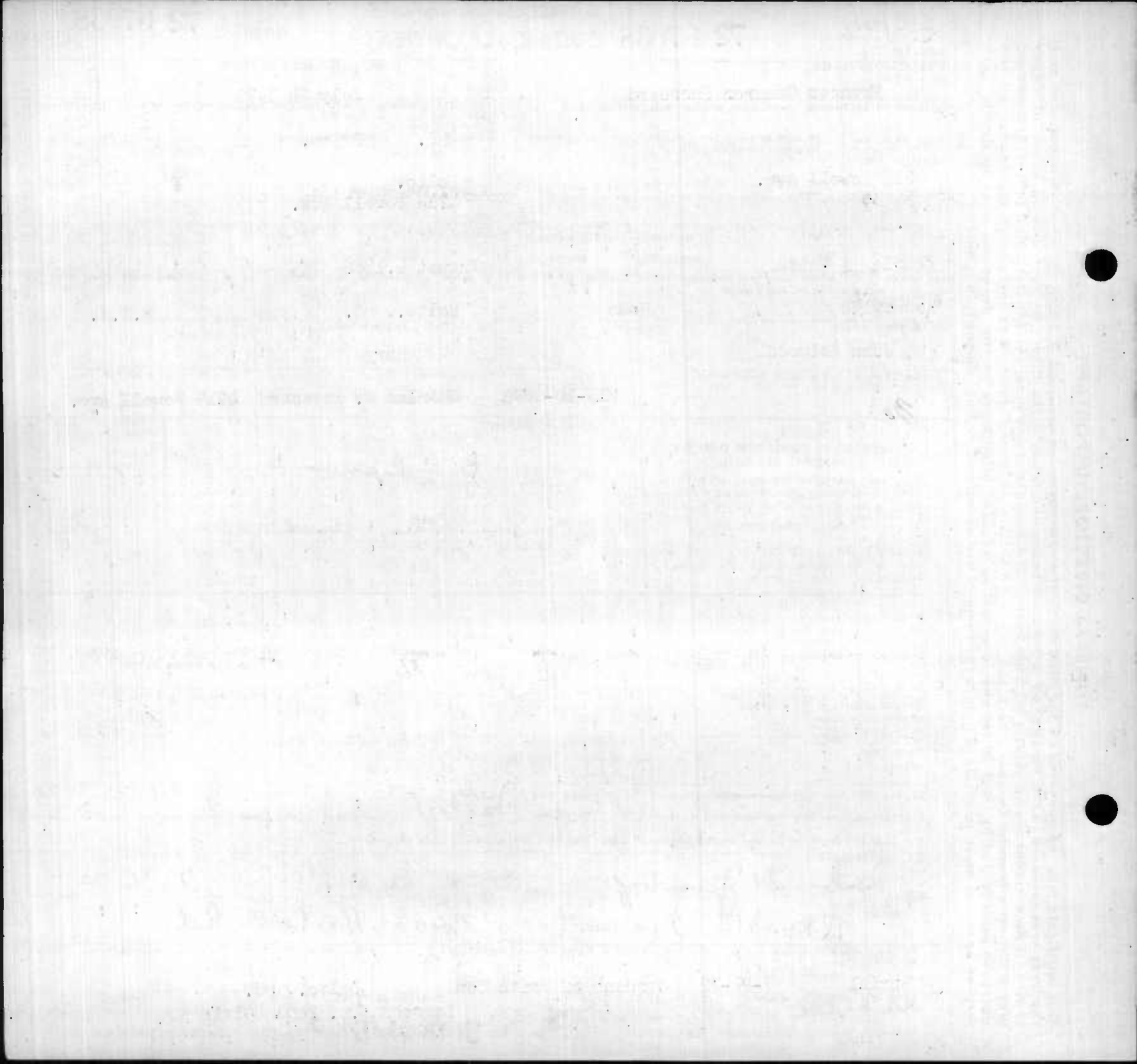
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07037 | | 72 07037 | |
|---|--|---|--|---|--|---|--|
| BIRTH NO. | | | | 72 07037 | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| Martha V. Bonneville | | | | 7-26-72 | | 4:00A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE Md. | | B. COUNTY 2404 | |
| 120 E. Barney Street Baltimore, Md. 21230 | | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER 120 E. Barney Street | | | | | | | |
| 5. SEX F | | 6. RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 4-18-1900 | |
| | | | | 9. AGE (In years last birthday) 72 | | 10. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY Md. | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 13. FATHER'S NAME Joseph Hughes | | | | 14. MOTHER'S MAIDEN NAME Martha Morris | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no. | | | | 16. SOCIAL SECURITY NO. 218-01-2441 | | 17. INFORMANT Mrs. Rosemarie Mustin (Sister) | |
| 18. 412-4 / 250-9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic CV disease | | | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: General arteriosclerosis | | years | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes mellitus | | | | 3 years | | | |
| 19A. DATE OF OPERATION none | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED --- | | 20A. AUTOPSY? (Yes or No) no. | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) --- | | 21C. WHERE DID INJURY OCCUR? --- | | (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) --- | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? --- | | | |
| 22. I certify that (I) (this hospital) attended the deceased from August 31, 1971 to July 26, 1972, that (I) (we) lost her the deceased alive on July 24, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE C. C. Chiu | | | | 23B. DATE SIGNED 7-26-72 | | | |
| 23C. PHYSICIAN'S NAME (Type) C. C. Chiu, M. D. | | | | 23D. ADDRESS 1 E. Randall Street, Baltimore, Md. 21230 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/29/72 | | 24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery | | 24D. LOCATION (City, town, or county) (State) Glen Burnie Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. Jul 27 1972 | | 25B. NAME OF REGISTRAR Anthony... | | 25C. FUNERAL DIRECTOR Mc Cully, Funeral Home | | ADDRESS 130 E. Fort Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>72 07038</u> |
|---|--|---|--|--|
| S-126 | | 72 07038 | | CERTIFICATE OF DEATH |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>Frances Cameron Spessard</u> | | |
| 2. DATE AND HOUR OF DEATH <u>July 24, 1972</u> <u>5 P.</u> M. | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4215 Powell Ave.</u> <u>00</u> | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u> | | C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| E. STREET AND NUMBER <u>4215 Powell Ave.</u> | | 5. SEX <u>Female</u> 6. RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 8. DATE OF BIRTH <u>August 4, 1886</u> <u>85</u> | | 9. AGE (In years last birthday) <u>85</u> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>John Astwood</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Mary</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | |
| 16. SOCIAL SECURITY NO. <u>215-10-0891</u> | | 17. INFORMANT <u>Charles H. Spessard</u> <u>4215 Powell Ave.</u> | | |
| 18. <u>412.3</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 year</u> |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>July 23</u> 19 <u>72</u> to <u>July 24</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>July 24, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <u>Ronald Jan Dorf</u> | | 23B. DATE SIGNED <u>7-26-72</u> | | 23C. PHYSICIAN'S NAME (Type) <u>R Donald Jan Dorf</u> |
| 23D. ADDRESS <u>7403 Hartford Rd</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | |
| 24B. DATE <u>7-27-72</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Gardens of Faith Cem</u> | | 24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u> |
| 25A. DATE RECEIVED BY HEALTH DEPT. <u>JUL 27 1972</u> | | 25B. NAME OF REGISTRAR <u>Donald Jan Dorf</u> | | 25C. FUNERAL DIRECTOR <u>Lassahn F.H.</u> <u>7401 Belair Rd</u> |



72 07039

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07039

REG. NO.

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) W. Fendlay JAMES KENDAY | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hosp. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 23 1972 7:25 p.m. | |
| 6. SEX male | | 7. RACE white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH April 18, 1908 | | 10. AGE (In years last birthday) 64 | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 15. MOTHER'S MAIDEN NAME Myrtle Miller | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT Mrs. Anna M. Fendlay | |
| 19. E900 X I | | ADDRESS Same | |
| CAUSE OF DEATH Heat stroke | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) no | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ? | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) ? | | 22D. TIME OF INJURY (APPROX.) 7-23-72 | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Apparent heat stroke during heat wave. | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Marvin S. Platt | | DATE SIGNED 7-24-72 | |
| EXAMINER'S NAME (Type) Marvin S. Platt, M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/26/72 | |
| 24C. NAME OF CEMETERY or CREMATORY Good Shepherd | | 24D. LOCATION (City, town, or county) (State) Ellicott City, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Audrey Johnston | |
| 25C. FUNERAL DIRECTOR Edw. S. MacNabb Sons, Inc. | | ADDRESS 301 Frederick Rd. Catonsville, Md. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|------------------|---|--|---|---------------------------------------|---|--|
| M-610 | | 72 07040 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07040 | |
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) MURPHY, SADIE PITHENIA | | | | 2. DATE AND HOUR OF DEATH JULY 23, 1972 9:10P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MARYLAND 21229 | | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| E. STREET AND NUMBER 5130 WESTLAND BLVD. | | | | | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 09 06 96 | 9. AGE (In years last birthday) 75 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME JOSEPH HADDAWAY | | | | 14. MOTHER'S MAIDEN NAME LYDIA BROWN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 217 01 8799 | | 17. INFORMANT ST AGNES RECORDS WILKENS & CATON AVES | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 I Acute infarct and septal MI DUE TO, OR AS A CONSEQUENCE OF: Cordiac arrest. 3 days 3 hrs | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that XIX (this hospital) attended the deceased from JULY 23, 19 72 to JULY 23, 19 72. that X (we) last saw the deceased alive on JULY 23, 19 72 and that in X (our) opinion death occurred on the date and hour and from the causes stated above X (We) (did) XXXX view the body after death. | | | | | | | |
| 23A. SIGNATURE [Signature] | | | | 23B. DATE SIGNED July 24, 1972 | | | |
| 23C. PHYSICIAN'S NAME (Type) DR JOSE APTE | | | | 23D. ADDRESS WILKENS & CATON AVE. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE July 27, 1972 | | 24C. NAME OF CEMETERY OR CREMATORY Baltimore National | | 24D. LOCATION (City, town, or county) (State) Catonsville Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Aldrich, [Signature] | | 25C. FUNERAL DIRECTOR Amberg Inc. 1348 Ralph [Signature] | | ADDRESS | |

5-10-50

RECEIVED JULY 22 1950

TO: DIRECTOR

FROM: SAC, NEW YORK

RE: ALGER HISS, JR.
WILLIAM C. GALT, JR.
SAC, NEW YORK

DATE: JULY 21, 1950

00 00 00

RE: ALGER HISS, JR.

RE: ALGER HISS, JR.

RE: ALGER HISS, JR.

RE: ALGER HISS, JR.

END

NO

TO: DIRECTOR

RE: ALGER HISS, JR.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07041

BIRTH NO.

| | | | | | | | |
|--|-------------------------|---|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Carrie E. Barnes | | | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 7/22/72 M. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3556 Poole Street | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 22 72 9:16 A. M. | | | |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1348 | | | | | | | |
| 6. SEX female | 7. RACE White | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH 2/15/03 | | 10. AGE (In years lost birthday) 69 | | E. STREET AND NUMBER 3556 Poole Street | | | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME ? | | | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Textile Worker | | 14B. KIND OF BUSINESS OR INDUSTRY Hoopers Mills | | 15. MOTHER'S MAIDEN NAME ? | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 17. SOCIAL SECURITY NO. 213-05051 | | 18. INFORMANT ADDRESS Howard A. Barnes 344 S. Bentlow St. | | | |
| 19. 4/2.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 21. AUTOPSY? (Yes or No) no | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <u>Marvin Platt</u> M.D. EXAMINER'S NAME (Type) Marvin Platt, M.D. DATE SIGNED 7/23/72 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/26/72 | | 24C. NAME of CEMETERY or CREMATORY St. Marys | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE RECEIVED BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Bridgette H. H. H. | | 25C. FUNERAL DIRECTOR ADDRESS Paul F. Chenoweth 3rd. 3617 Chestnut Ave | | | |

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S-160

72 07042 STATE OF MARYLAND-DEMH
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07042

BIRTH NO. 7207128

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) STANLEY SCIBER (Scriber) | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 130 N. Asquith St. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 23 1972 12:05p M. | |
| 6. SEX male | | 7. RACE negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 10. AGE (In years last birthday) 10 wks. | | E. STREET AND NUMBER 130 N. Asquith St. | |
| 11. BIRTHPLACE (State or foreign country) Balto. Md. | | 13. FATHER'S NAME Stanley Scriber | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby | | 15. MOTHER'S MAIDEN NAME Paula Hatten | |
| 14B. KIND OF BUSINESS OR INDUSTRY None | | 18. INFORMANT Paula Hatten | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | ADDRESS SAME | |
| 17. SOCIAL SECURITY NO. | | 19. 795X | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | CAUSE OF DEATH Sudden Death in Infancy (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION | | 21. AUTOPSY? (Yes or No) yes | |
| 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 23. | |
| I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Marvin S. Platt, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-24-72 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burned | | 24B. DATE 7-28-72 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem. | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Adrian [illegible] | |
| 25C. FUNERAL DIRECTOR E. Q. Wilson | | ADDRESS 1000 Brantly Ave. Balto. Md. | |

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MAIL ROOM

B-640

72 07043

STATE OF MARYLAND-DEMP
BALTIMORE CITY HEALTH DEPARTMENT

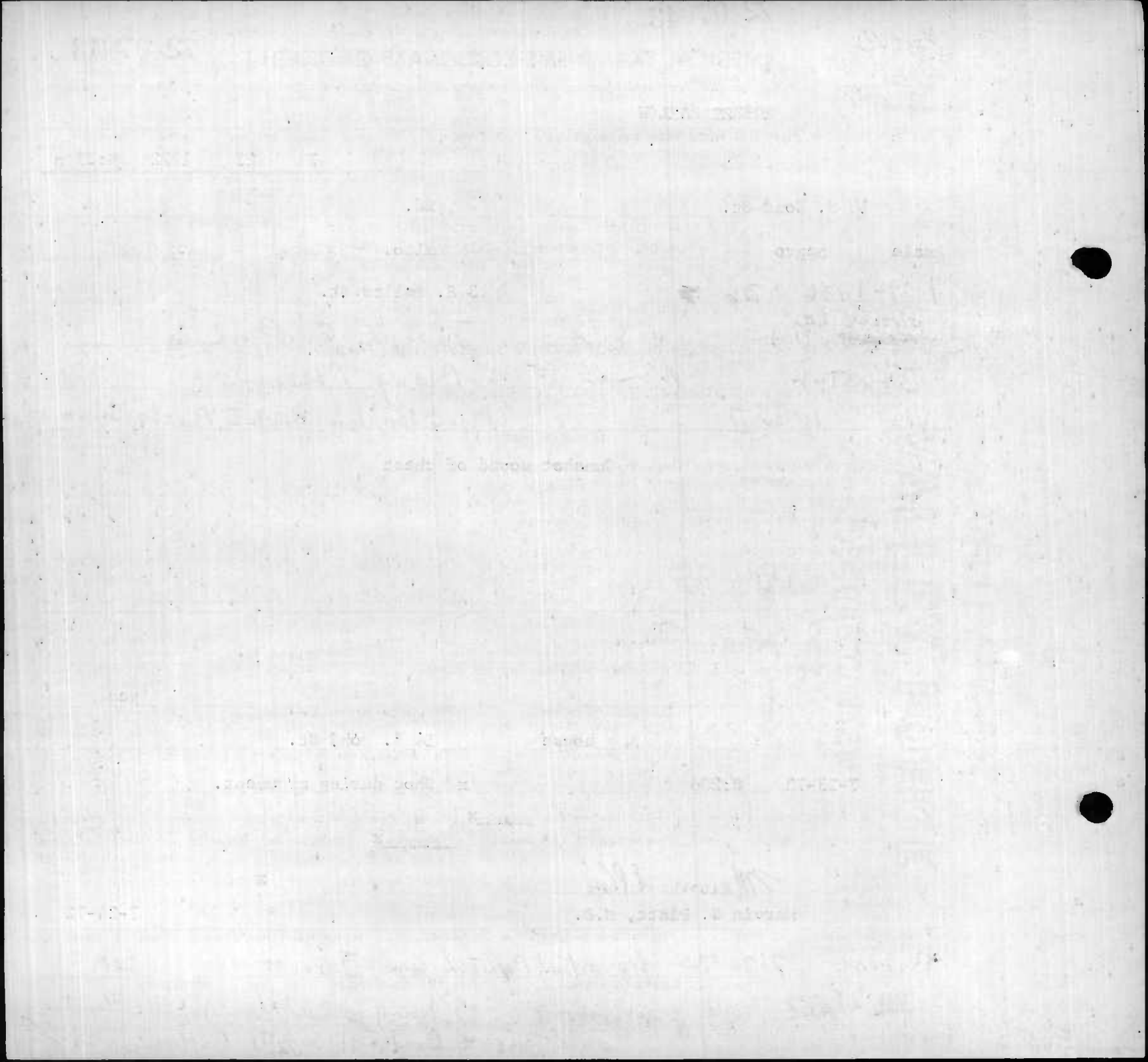
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07043

REG. NO.

BIRTH NO.

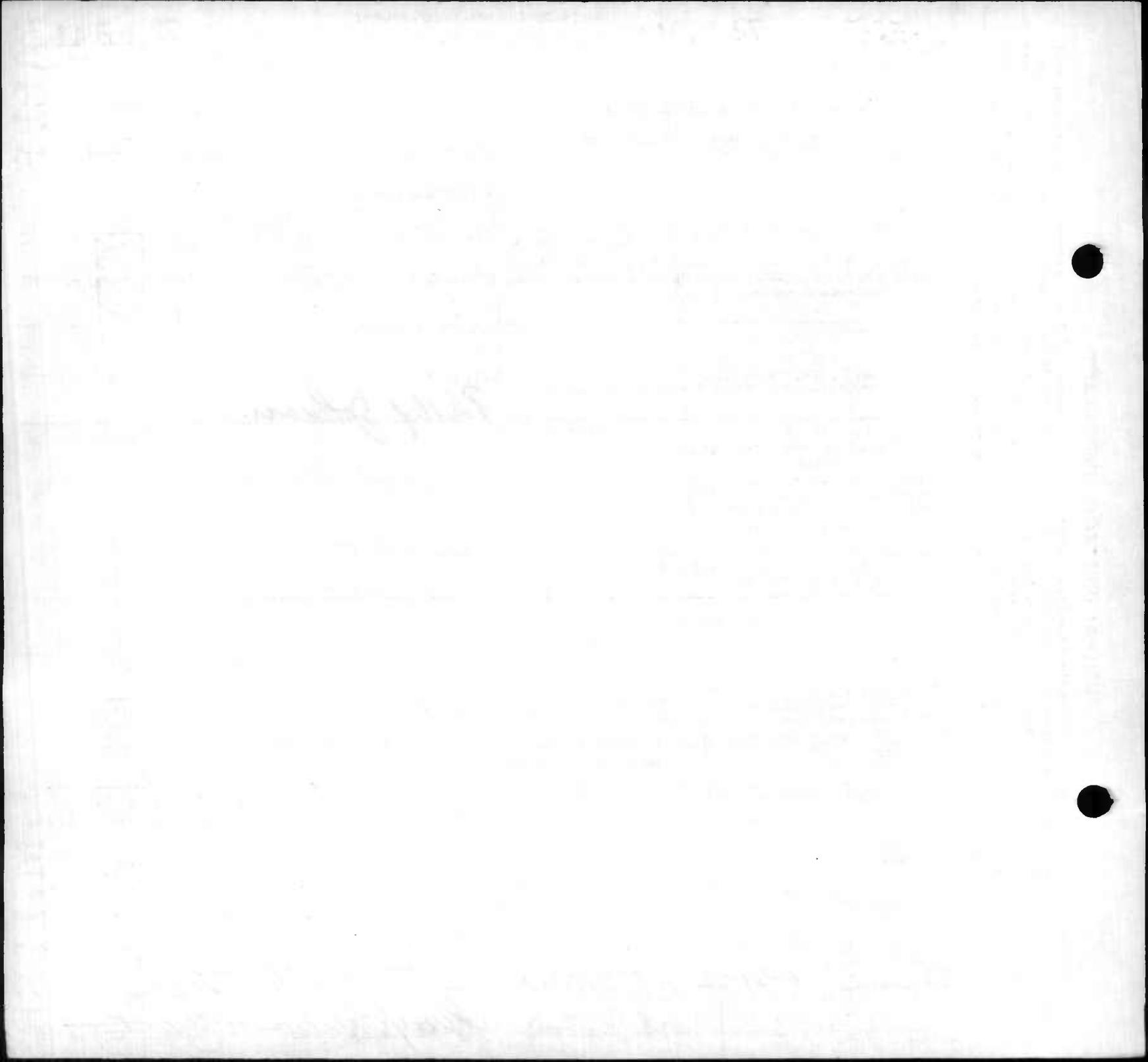
| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) ROBERT BARLOW | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 14 S. Bond St. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 23 1972 8:35 p M. | |
| 6. SEX male | | 7. RACE negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 1-9-1936 | | 10. AGE (In years last birthday) 36 | |
| 11. BIRTHPLACE (State or foreign country) Greenville, S.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph C. Barlow | | 14. MOTHER'S MAIDEN NAME Mary Mason | |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor | | 16. KIND OF BUSINESS OR INDUSTRY None | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII | | 18. SOCIAL SECURITY NO. | |
| 19. INFORMANT Mary Barlow | | ADDRESS Route 1 Box 203, Jarrett, Va. | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of chest ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) house | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 14 S. Bond St. | | 22D. HOW DID INJURY OCCUR? Shot during argument. | |
| 22E. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 7-23-72 8:20p m. | | 22F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Marvin S. Platt, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-24-72 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-30-72 | |
| 24C. NAME OF CEMETERY or CREMATORY Hasadiah Baptist Ch. Cem. | | 24D. LOCATION (City, town, or county) (State) Jarrett VA. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Joseph E. Bond | |
| 25C. FUNERAL DIRECTOR Phonny O. Wilson | | ADDRESS 1000 Brantley Ave. Jarrett, Va. | |



FUNERAL DIRECTOR: IMPORTANT

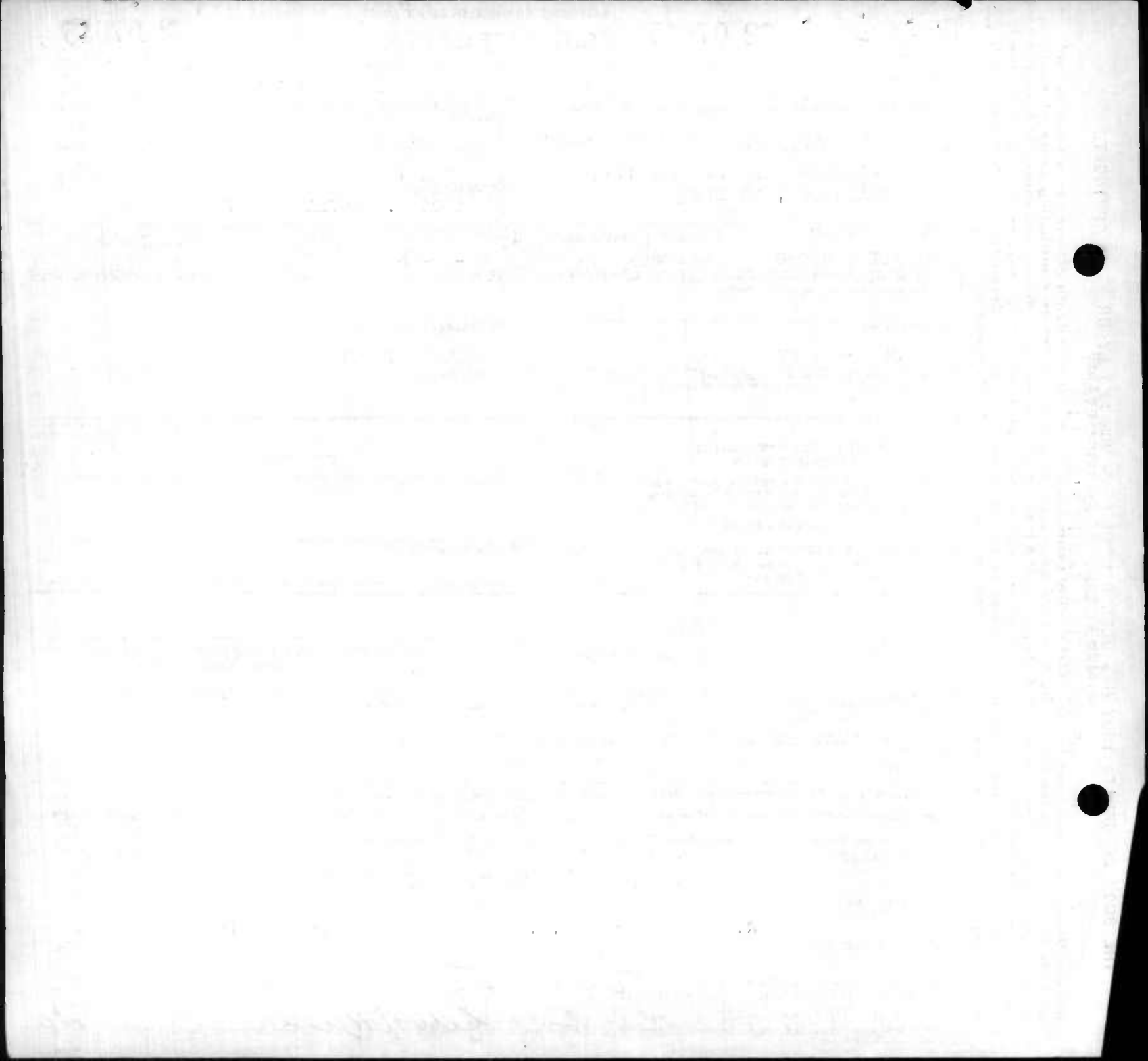
This certificate must be approved by the chief medical examiner, or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| J-525 72 07044 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07044 | |
|--|------------------|---|-----------------------------------|---|---|---|--|
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| Mr. Johnson Wesley | | | | July 25, 1972 6:40 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | A. STATE Maryland Baltimore | | B. COUNTY | |
| The Union Memorial Hospital | | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 44 | | | | E. STREET AND NUMBER 1500 Cliftview Avenue; Balto. 15 MD. | | | |
| 5. SEX MALE | 6. RACE BLACK | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-19-22 | 9. AGE (In years lost birthday) 49 | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? AMERICAN |
| 13. FATHER'S NAME Lorraine Johnson | | | | 14. MOTHER'S MAIDEN NAME FLOYD CORA | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Phillip Johnson | | ADDRESS | |
| 18. 347.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Primary Brain Damage. Dehydration (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | | |
| 19. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 11 19 72 to July 25 19 72 | | that (I) (we) last saw the deceased alive on July 19 19 72 | | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Pedro Barba M.D. | | | | 23B. DATE SIGNED 07-25-72 | | 23C. PHYSICIAN'S NAME (Type) Pedro Barba M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 7-29-72 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | | | 25B. NAME OF REGISTRAR Aldrey Johnson | | 25C. FUNERAL DIRECTOR Eloy Wilson | |
| 26A. ADDRESS 1500 Cliftview Avenue; Balto. 15 MD. | | | | 26B. ADDRESS | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07045 | |
|---|-------------------------|---|-------------------------------------|---|---|
| T-600 72 07045 BIRTH NO. 68-15486 | | 72 07045 | | Dead on Arrival | |
| 1. NAME OF DECEASED (Type or Print) <u>Troy, Bonita</u> | | 2. DATE AND HOUR OF DEATH <u>July 22, 1972 6:00 A.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>805</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205</u> | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <u>1901 N. CASTLE STREET</u> | | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>NEGRO</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>08-08-68</u> | 9. AGE (In years last birthday) <u>3</u> | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | |
| 13. FATHER'S NAME <u>JOSEPH TROY</u> | | 14. MOTHER'S MAIDEN NAME <u>RENEE DICKEY</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. <u>273.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cystic Fibrosis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cystic Fibrosis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>From birth</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>July 22, 1972</u> to <u>1972</u> and that (1) (we) last saw the deceased alive on <u>July 22, 1972</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Roger R. Brumback</u> | | 23B. DATE SIGNED <u>7/22/72</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>ROGER R. BRUMBACK M.D.</u> | | 23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>7-25-72</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Not Auburn City</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Bald Md</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 27 1972</u> | | 25B. NAME OF REGISTRAR <u>Alvin Johnson</u> | | 25C. FUNERAL DIRECTOR <u>Chas. Wilson or Crutcher</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| W-623 72 07046 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07046 | |
|--|--|---|--|---|--|--|--|
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| WRIGHT, HOWARD | | | | JULY 19, 1972 12:55 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | | | |
| 33 THE JOHNS HOPKINS HOSPITAL | | | | MARYLAND | | | |
| C. CITY OR TOWN | | | | D. INSIDE CITY LIMITS? | | | |
| BALTIMORE | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER | | | | 1234 DARLEY AVE. | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| MALE | | NEGRO | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 03-19-15 | |
| 9. AGE (In years last birthday) | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 57 | | City Employee | | None | | Balto. Md. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| JAMES WRIGHT | | Laura Morris | | No | | 217-03-5511 | |
| 17. INFORMANT | | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | 19. DATE OF OPERATION | | 20. AUTOPSY? (Yes or No) | |
| Evenlyn Wright - Same | | PROBABLE BOWEL OBSTRUCTION | | 2 | | YES | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 1 WK | | CARCINOMA OF THE COLON | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) _____ | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | 22. I certify that (I) (this hospital) attended the deceased from JULY 18 1972 to JULY 19 1972 that (I) (we) last saw the deceased alive on JULY 19 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE | | 23B. DATE SIGNED | |
| JAMES KINGSBURY BROWN M.D. | | 7/19/72 | | 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | |
| JAMES KINGSBURY BROWN M.D. | | THE JOHNS HOPKINS HOSPITAL | | 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | |
| Burial | | 7-24-72 | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BALTO. CEM. | | BALTIMORE MD. | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | |
| JUL 27 1972 | | L. J. Wilson | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| 1000 Brattle Ave. | | | | | | | |

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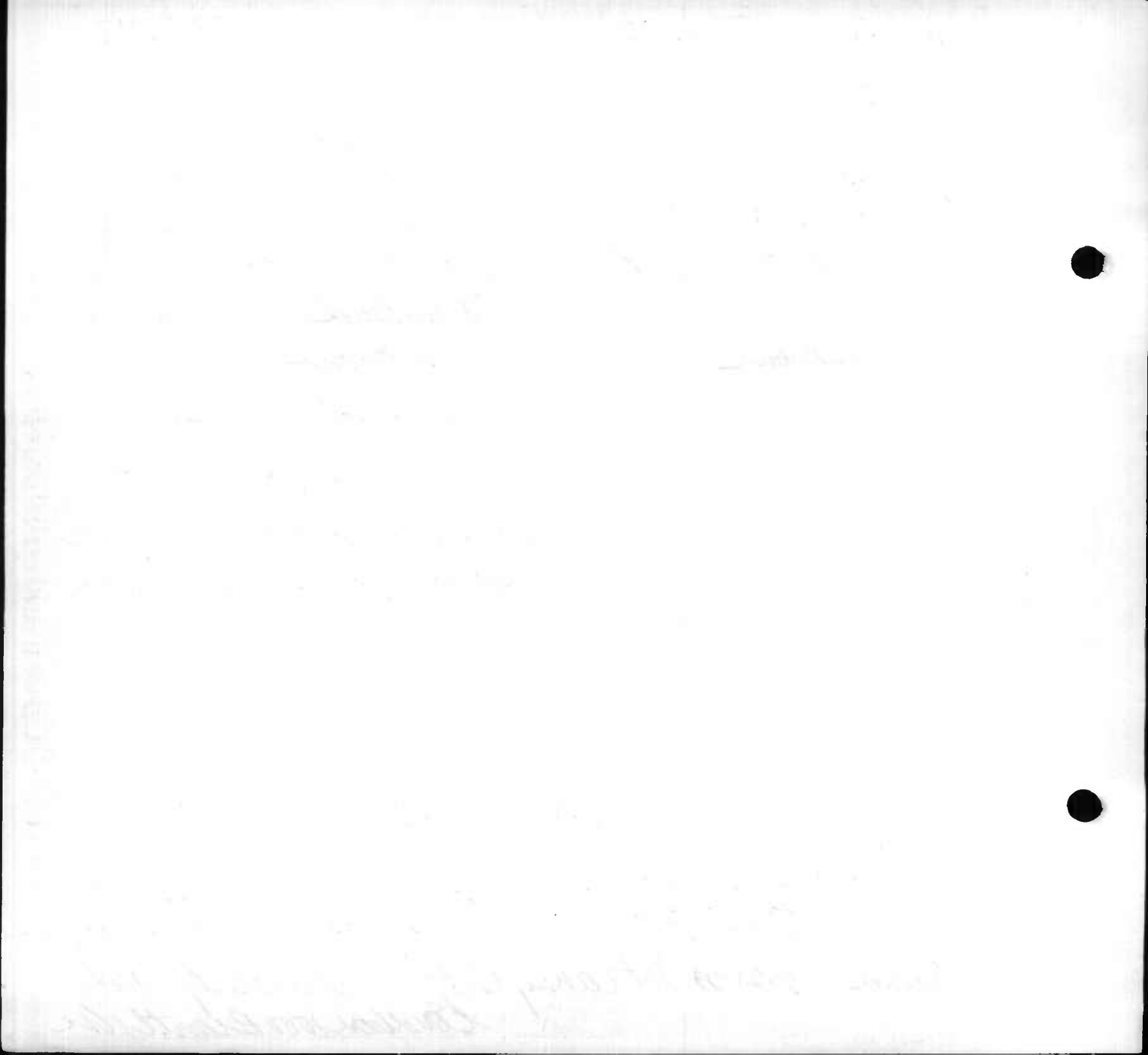
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

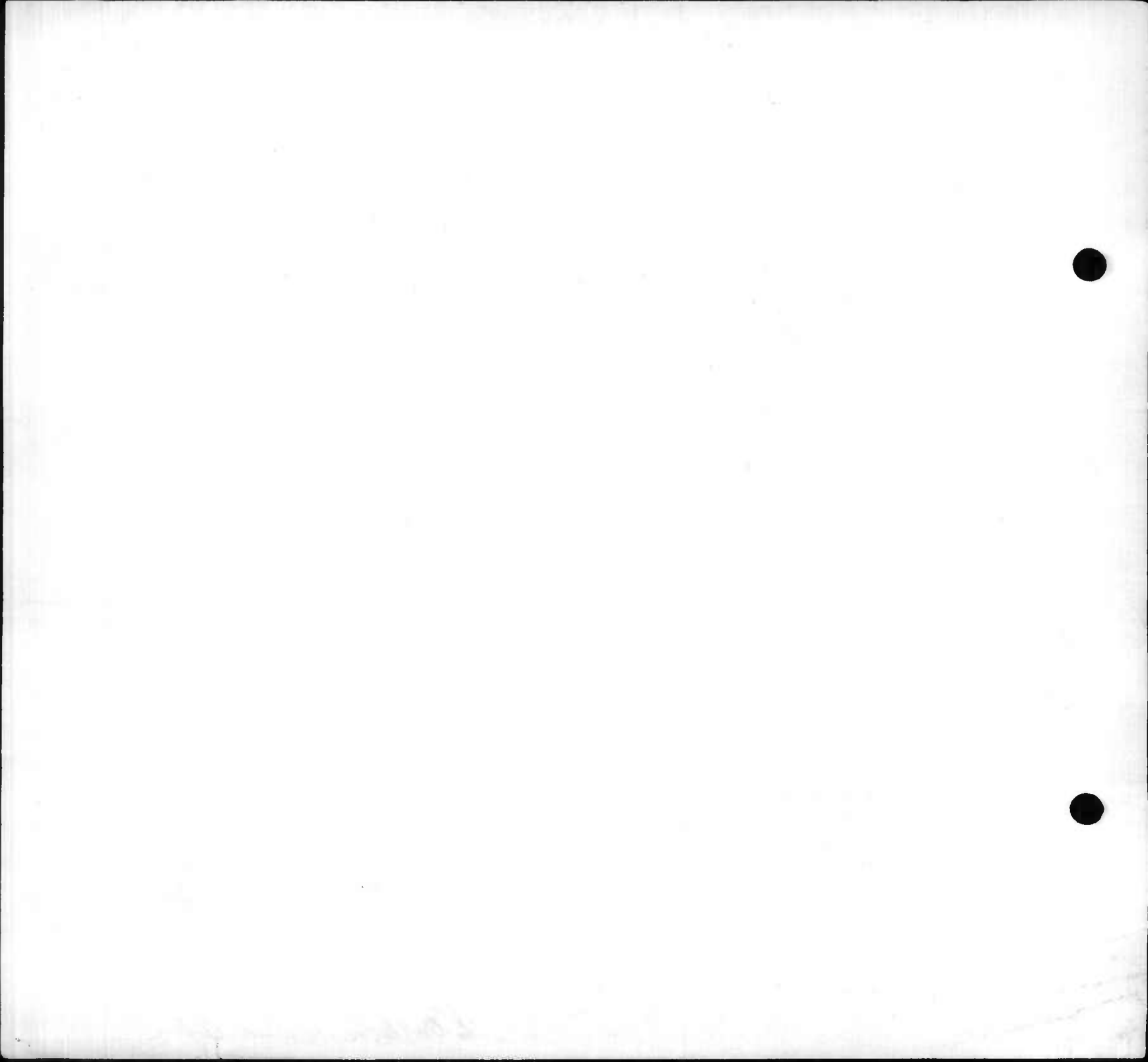
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|---|-------------------------|---|-----------------------------------|---|--|--|--|
| M-620 | | 72 07047 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07047 | |
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Rose Morris B</i> | | | | 2. DATE AND HOUR OF DEATH <i>7-24-72</i> <i>5pm</i> M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Bolton Hill Nursing home</i> <i>1400 John St</i> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1538</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>2503 ELSINORE AVE</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>Black</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>7-4-19</i> | 9. AGE (In years last birthday) <i>53</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i> |
| 13. FATHER'S NAME <i>unknown</i> | | | | 14. MOTHER'S MAIDEN NAME <i>unknown</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>admission Records</i> | | ADDRESS | |
| 18. <i>412.31</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial Infarction</i> (B) <i>arteriosclerotic heart disease</i> (C) <i>arteriosclerotic</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>weeks</i> <i>years</i> <i>years</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>7/20</i> 19 <i>72</i> to <i>7/24</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>7/24</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Dr. Macht</i> | | | | 23B. DATE SIGNED <i>7/25/72</i> | | 23C. PHYSICIAN'S NAME (Type) <i>Dr. Macht</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <i>7-28-72</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Mt Carmel</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JUL 27 1972</i> | | 25B. NAME OF REGISTRAR <i>Dr. Macht</i> | | 25C. FUNERAL DIRECTOR <i>Dr. Macht</i> | | ADDRESS <i>1000 Pennsylvania Ave</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

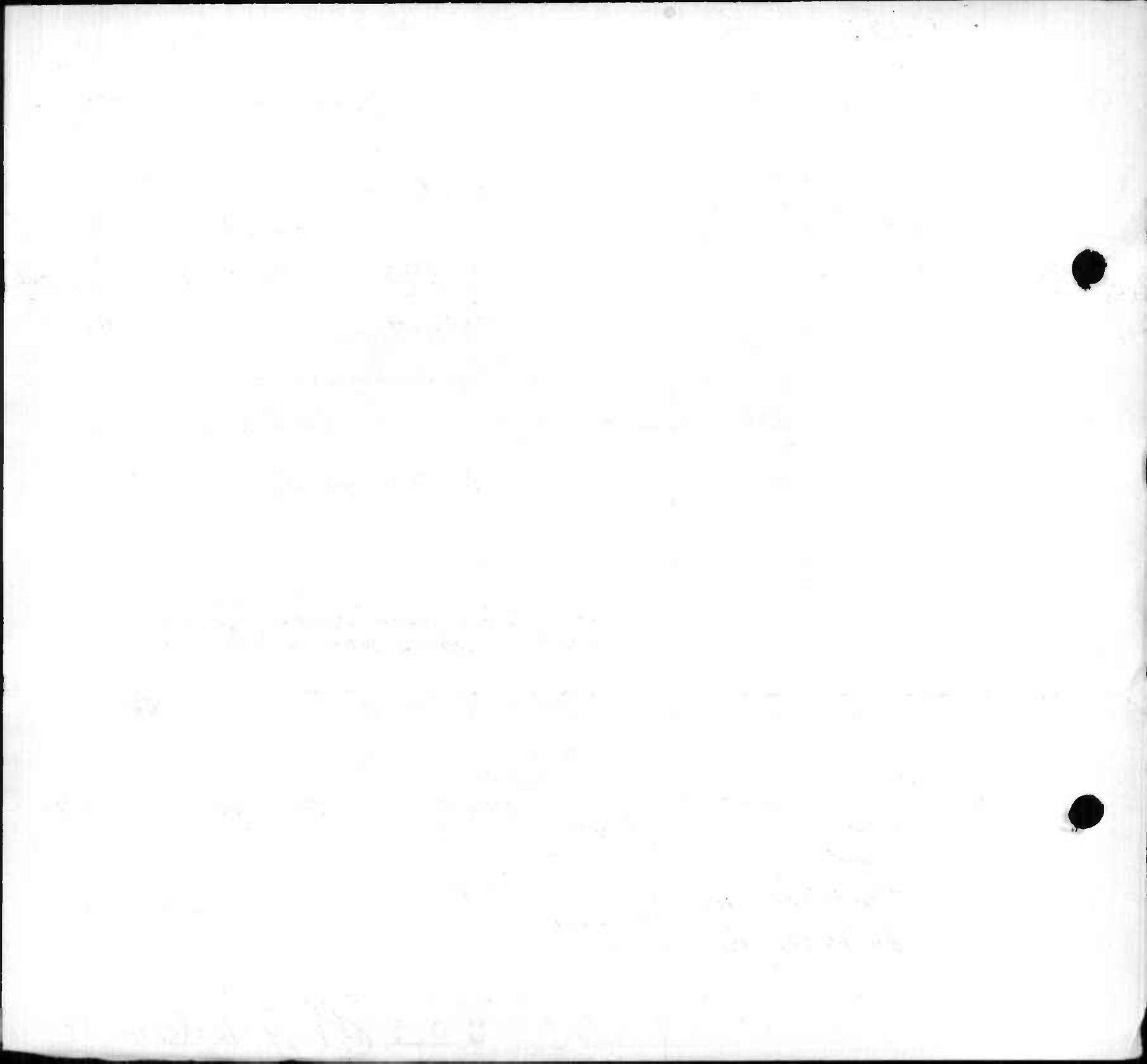
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|--|------------------------|---|----------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07048 | |
| 7-630 | | 72 07048 | |
| CERTIFICATE OF DEATH | | STATE OF MARYLAND-DEMH | |
| 1. NAME OF DECEASED (Type or Print) Ford, Bessie | | 2. DATE AND HOUR OF DEATH 7-25-72 10:50 AM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD HARBOR VEU NURSING HOME | | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Maryland B. COUNTY 1601 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) HARBOR VEU NURSING HOME | | C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER 1101 Harbor Ave. | | | |
| 5. SEX Female | 6. RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-3-1896 |
| 9. AGE (In years last birthday) 76 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William Thomas | | 14. MOTHER'S MAIDEN NAME Minnie Minter | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. — | |
| 17. INFORMANT Joseph Ford | | ADDRESS 1524 N. Kenwood Ave. | |
| 18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: A.S.C. V. D. | |
| | | (B) Diabetes Mellitus | |
| | | (C) CVA | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 20B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21A. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21C. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21D. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/25 19 72 to 7/25 19 72 that (I) (we) lost saw the deceased alive on 7/25 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Joseph S. Brown | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) JOSEPH S. BROWN | | 23D. ADDRESS 1115 N. CALVERT ST | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burned | | 24B. DATE 7-29-72 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem. | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Henry H. [Signature] | |
| 25C. FUNERAL DIRECTOR [Signature] | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

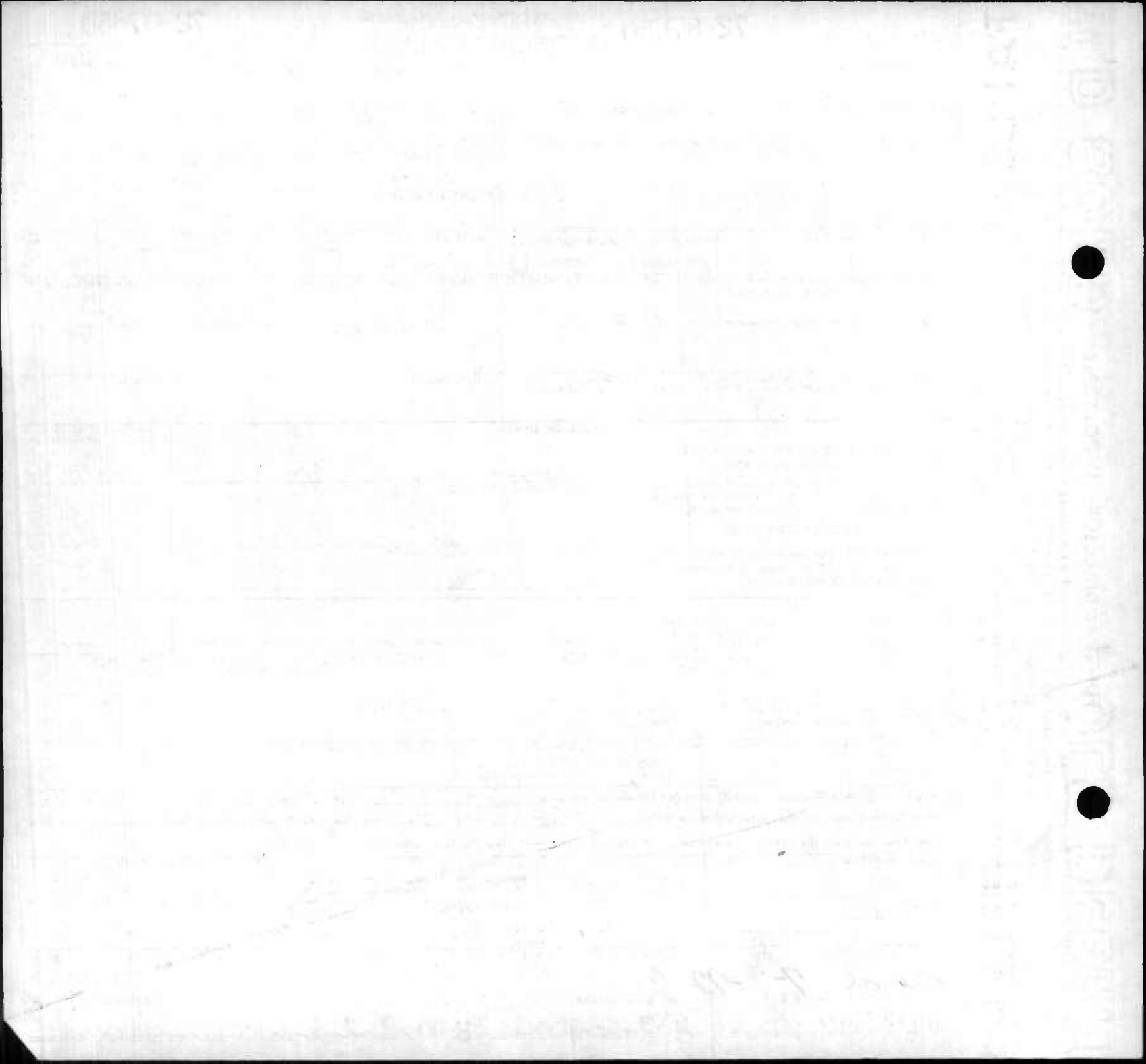
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|---|---------------------|---|--|--|--|---|--|
| N-620 | | 72 07049 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07049 | |
| CERTIFICATE OF DEATH | | | | STATE OF MARYLAND-DIME | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Norris Gertrude</u> | | | | 2. DATE AND HOUR OF DEATH <u>7/16/72</u> <u>7:55 AM</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>18501</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bolton Hill Nursing Home</u> <u>Lafayette & Johns Sts.</u> <u>Baltimore, Maryland</u> | | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER <u>802 W. Lex. St.</u> | | | | | | | |
| 5. SEX <u>F</u> | 6. RACE <u>B</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>3-14-87</u> | 9. AGE (in years last birthday) <u>85</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Georgia</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME <u>Include Case</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>W</u> | | | | 16. SOCIAL SECURITY NO. <u>215-15-0622</u> | | 17. INFORMANT <u>Dolores Ricks 600 Claymont Ave</u> | |
| 18. <u>412-4 + 096X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ASCVD - Compensated CHF</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic Brain Syndrome, Diverticulitis of Colon</u> <u>Late Latent Syphilis, Abdominal Aortic Aneurysm</u> | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD - Compensated CHF</u> Years <u>Years</u> | | (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Chronic Brain Syndrome, Diverticulitis of Colon</u> <u>Late Latent Syphilis, Abdominal Aortic Aneurysm</u> | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>May 17</u> 19 <u>72</u> to <u>July 16</u> 19 <u>72</u> that <u>W</u> (we) last saw the deceased alive on <u>July 16</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Peter H Rheinster, MD</u> DEGREE <u>MD</u> 23C. PHYSICIAN'S NAME (Type) <u>Dr. Peter Rheinster</u> 525-6790 | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>July 18, 1972</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <u>7-20-72</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Mount Carmel</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore</u> | |
| 25A. DATE RECD. BY HEALTH DEPT. <u>JUL 27 1972</u> | | 25B. NAME OF REGISTRAR <u>Sidney H. Hinton</u> | | 25C. FUNERAL DIRECTOR <u>304</u> | | ADDRESS <u>Edgar Wilson</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|--|---|--|--|--|---|--|
| 7-520 | | 72 07050 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07050 | |
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Fenwick, Julia</u> | | | | 2. DATE AND HOUR OF DEATH <u>7/24/72</u> <u>14:28</u> <u>A.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Baltimore City, Maryland</u> B. COUNTY <u>806</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Johns Hopkins Hospital</u> | | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <u>F</u> 6. RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH <u>4/04/02</u> | | 9. AGE (in years last birthday) <u>70</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>Imbrie</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>410-9-1</u> | | 17. INFORMANT <u>Michael Steven Katz</u> | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac Arrest</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>45"</u> | |
| (B) <u>Acute myocardial infarction</u> | | | | (C) _____ | | <u>8 days</u> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (we) (this hospital) attended the deceased from <u>7/16</u> 19 <u>72</u> to <u>7/24</u> 19 <u>72</u> that (we) last saw the deceased alive on <u>7/24</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Michael Steven Katz, MD</u> | | | | 23B. DATE SIGNED <u>July 24, 1972</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Michael Steven Katz, M.D.</u> | | | | 23D. ADDRESS <u>Apt 804, 550 N Broadway, Balt, Md 21205</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>7-72</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>New Catholic Cem.</u> | | 24D. LOCATION (City, town, or county) (State) <u>Balt.</u> <u>md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 27 1972</u> | | 25B. NAME OF REGISTRAR <u>Lidney</u> | | 25C. FUNERAL DIRECTOR <u>Wilton</u> | | ADDRESS <u>1002 Broadway</u> | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07051

BIRTH NO.

REG. NO.

| | | | | | | | |
|---|-------------------------|---|--|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) JOSHUA GROSS | | | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 7 25 72 M. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 LUTHERAN HOSPITAL | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour July 25, 1972 1:45 P. M. | | | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1703 | | | | | | | |
| 6. SEX Male | 7. RACE Negro | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH 1-5-1921 | | 10. AGE (In years last birthday) 51 | | 11. BIRTHPLACE (State or foreign country) BALTO. Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WILLIAM E. GROSS | | | | 14. MOTHER'S MAIDEN NAME ELIZABETH HENSON | | | |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR | | | | 16. KIND OF BUSINESS OR INDUSTRY | | | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 18. SOCIAL SECURITY NO. 219-01-4010 | | 19. INFORMANT ADDRESS MYRTLE WARRINGTON 2825 W. NORTH AVE | |
| 19. E 988X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | CAUSE OF DEATH Acute subdural hemorrhage (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| 20A. DATE OF OPERATION 2 | | | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 21. AUTOPSY? (Yes or No) yes | | | | | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unk. | | | |
| 22C. WHERE DID INJURY OCCUR? Unk. | | | | | | | |
| 22D. TIME OF INJURY (APPROX.) unk. | | | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 22F. HOW DID INJURY OCCUR? Unk. | | | | | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/26/72 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 7-29-72 | | 24C. NAME OF CEMETERY or CREMATORY MT. CALVERY | | 24D. LOCATION (City, town, or county) (State) BALTO. Md | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Sidney W. Hays | | 25C. FUNERAL DIRECTOR Sidney W. Hays | | ADDRESS 3112 Pennington Rd | |

1941

William E. Gross

Charles H. Hanson

Washington, D.C.

1941

1941

1941

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|---|--|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | 72 07052 | | REG. NO. 72 07052 | |
| S.362 | | 72 07052 | | STATE OF MARYLAND-DEME | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) STRAS BAUGH, Mr HARRY B. | | 2. DATE AND HOUR OF DEATH 7/25/72 9-15 PM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY BALTIMORE | | M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION Church Home Hospital 35 | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN DUNDALK D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| E. STREET AND NUMBER 2905 DUNELLOW Rd 21222 | | 5. SEX M 6. RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 9-23-90 | | 9. AGE (In years last birthday) 81 yr | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN | | 10B. KIND OF BUSINESS OR INDUSTRY STEEL MFR. | | 11. BIRTHPLACE (State or foreign country) PA. AMER | |
| 12. CITIZEN OF WHAT COUNTRY? AMERICA | | 13. FATHER'S NAME JOHN STRAS BAUGH | | 14. MOTHER'S MAIDEN NAME EMMA E. POOK. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO | | 16. SOCIAL SECURITY NO. 213 07 9659 | | 17. INFORMANT SEANETTE V. STRASBAUGH, wife | |
| 18. CAUSE OF DEATH | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio pulmonary Arth | | | |
| ANTECEDENT CAUSES | | (B) Apathetic Anemic Aseptic | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) CVA | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Involuntarily medical examined <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) [APPROX.] | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (this hospital) attended the deceased from 7/13/72 to 7/25/72 | | that (I) (we) lost saw the deceased alive on 7/25/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE L. PADMARASU | | 23B. DATE SIGNED 7/25/72 | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | |
| 23C. PHYSICIAN'S NAME (Type) L. PADMARASU | | 23D. ADDRESS CHURCH HOME HOSPITAL | | 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | |
| 24B. DATE 7/29/72 | | 24C. NAME OF CEMETERY OR CREMATORY OAK LAWN | | 24D. LOCATION (City, town, or county) BALTO. CO., MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Sidney Whitton | | 25C. FUNERAL DIRECTOR W. S. Dwyer, Dundalk, Md. | |

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February 1881

No

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1881

1881

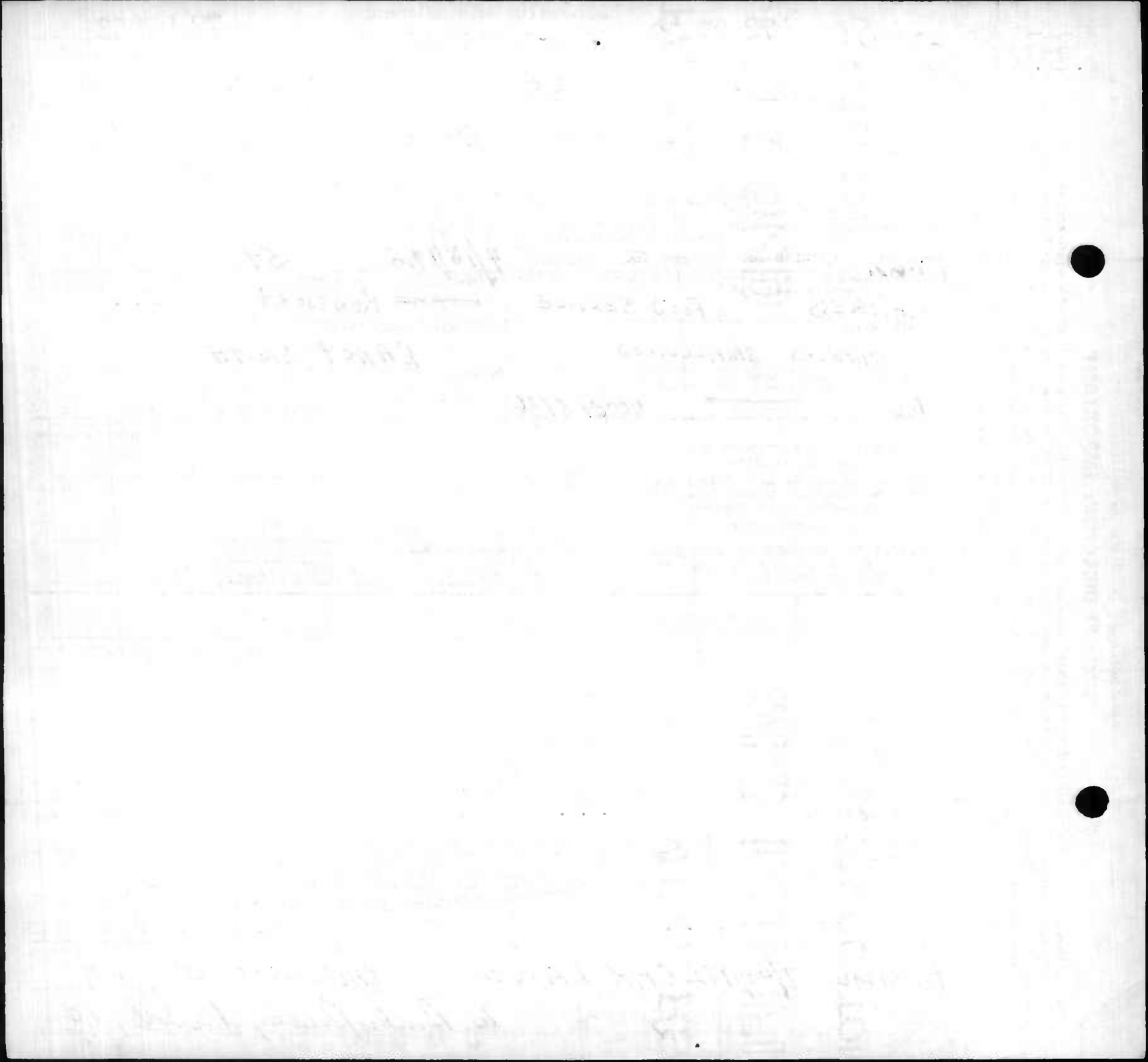
41-22-01 djr

D.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|--|---|--|--|--|--|--|
| T-200 | | 72 07053 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07053 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | STATE OF MARYLAND-DHMH | | | |
| 1. NAME OF DECEASED (Type or Print) | | BERNICE ICE | | 2. DATE AND HOUR OF DEATH | | 7/25/72 9 AM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY | | Maryland | | 2611 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Lobach City Hosp. 4940 Eastern Avenue Baltimore, Md. 21224 | | E. STREET AND NUMBER | | 3312 Harmony CT | | 21224 | |
| 5. SEX Female | | 6. RACE Caucasian | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 4/18/1918 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (in years last birthday) 54 | | 11. BIRTHPLACE (State or foreign country) | |
| WAITRESS | | FOOD SERVICE | | Maryland KENTUCKY | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME CHARLES SMALLWOOD | | 14. MOTHER'S MAIDEN NAME NANCY SMITH | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 40034 8736 | |
| 17. INFORMANT BCH: RECORDS | | ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224 | | 18. CAUSE OF DEATH 519.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Respiratory-cardiovascular arrest COPD, AIVD old @ ASD S/P left single mastectomy ASCVD inf. Transmural MI Septal | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-25 19 72 to 7-25 19 72 that (I) (we) last saw the deceased alive on D.O.A. 19 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE Peter J. Dorsen MD | | 23B. DATE SIGNED 7-25-72 | | | |
| 23C. PHYSICIAN'S NAME (Type) Peter Dorsen, M.D. | | 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 7/28/1972 | |
| 24C. NAME OF CEMETERY OR CREMATORY OAK LAWN | | 24D. LOCATION (City, town, or county) (State) BALTIMORE CO., MD | | 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Dorothy Whitton | |
| 25C. FUNERAL DIRECTOR W. Bruce Buckley, Kershaw, Ky | | 25D. ADDRESS | | VS 150-REV. 1/1/68 | | | |



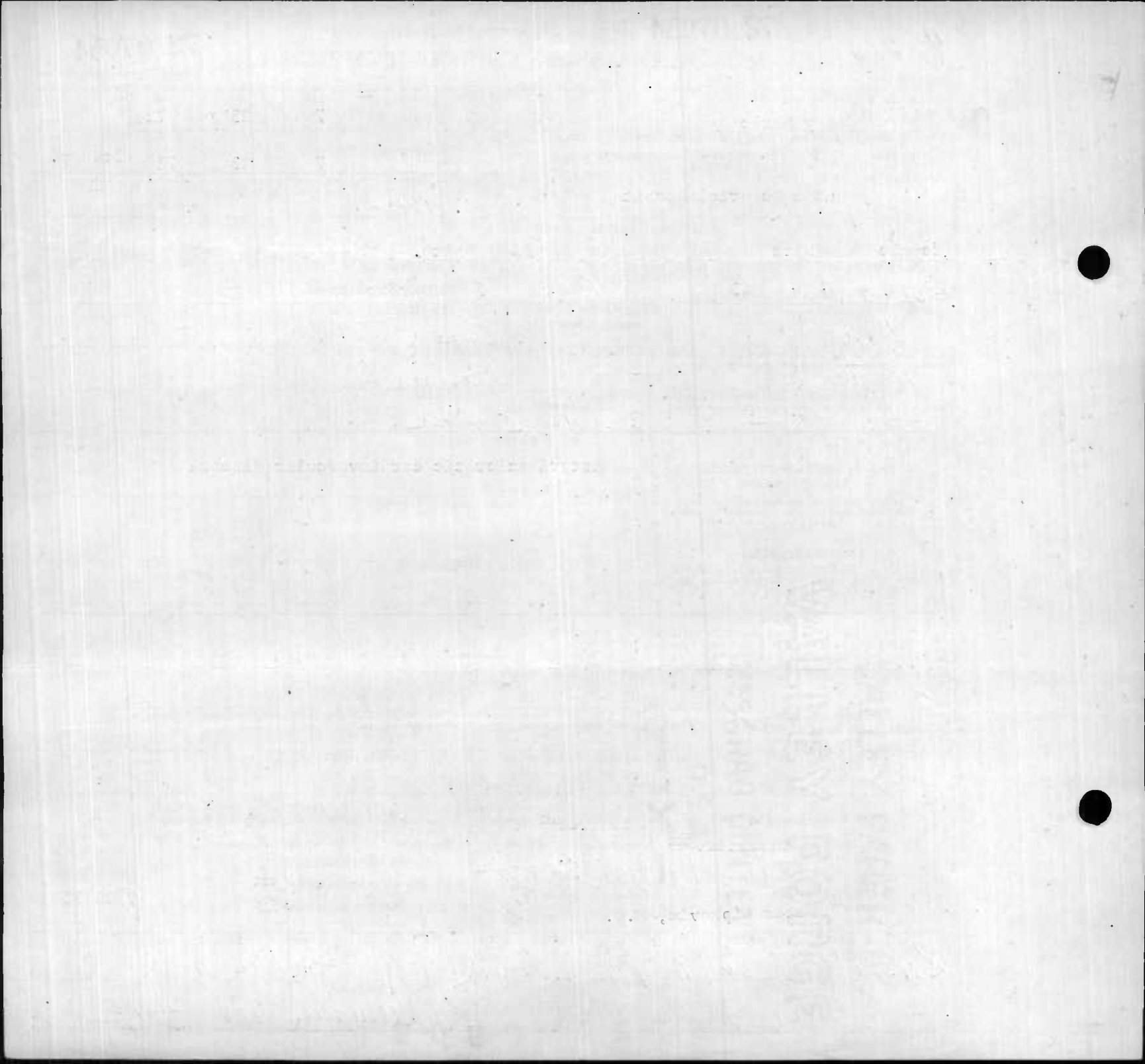
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07054

REG. NO.

BIRTH NO.

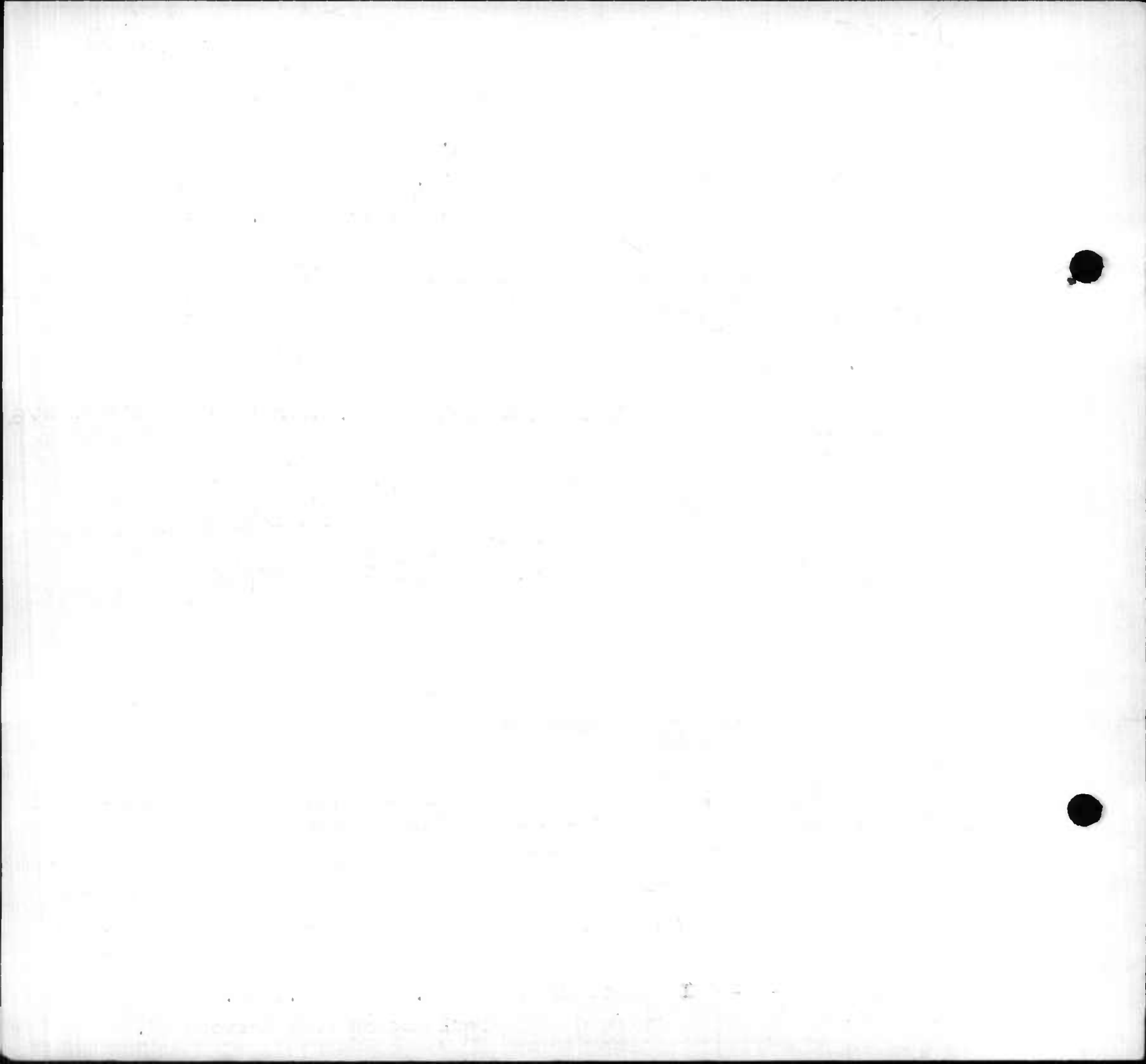
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|--|-------------------------|---|--|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) May Barbe | | | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 7 23 72 M. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 23 72 2:20 p. M. | | | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2706 | | | | | | | |
| 6. SEX female | 7. RACE White | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | C. CITY OR TOWN Balto. | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH July 8, 1909 | | 10. AGE (In years lost birth day) 63 | | E. STREET AND NUMBER 5806 Harford Road | | | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME Emory T. Chhardt | | | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME Hennie M. | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. 215-24-3975 | | 18. INFORMANT ADDRESS Jon | | | |
| 19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 21. AUTOPSY? (Yes or No) no | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7/24/72 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/26/72 | | 24C. NAME of CEMETERY or CREMATORY Moulton | | 24D. LOCATION (City, town, or county) (State) Balto Md | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Adrian B. Horton | | 25C. FUNERAL DIRECTOR Off Deemann | | ADDRESS 6067 Harford Rd | |



FUNERAL DIRECTOR: IMPORTANT

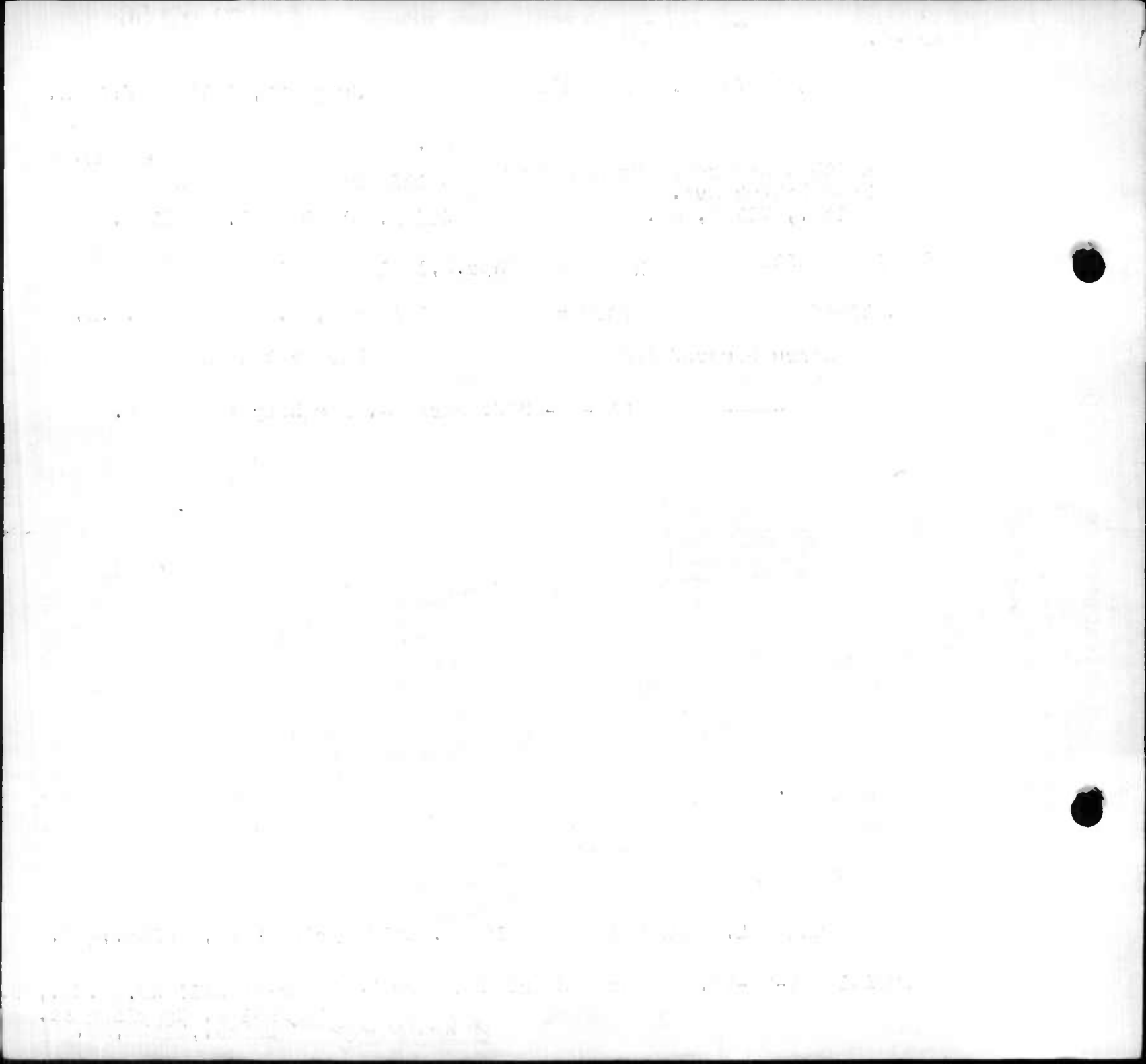
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| D-355 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07055 | | CERTIFICATE OF DEATH | | REG. NO. 72 07055 | |
|--|--|--|--|---|--|--|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | DITMAN KATHARINE | | 2. DATE AND HOUR OF DEATH | | 7-22-72 9.20 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | Md. | | 5. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital 827, Linden Avenue, Baltimore, Md. 21201. | | A. STATE | | B. COUNTY | | Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | |
| F | | W | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 3-29-05 | | 67 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Housewife | | Home | | Maryland | | U S A | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| Henry W. Meurer | | Katharine Dederer | | no | | 215 10 8604 | | Katharine E. Ditman 3310 Southern Ave. | |
| 18. CAUSE OF DEATH | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | Respiratory Failure | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | O.A.S.C.V.D. | | | |
| | | | | (C) | | Occlusion Internal carotid Artery | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | | | | no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from | | 7-14-1972 to | | 7-22-1972 | | that (I) (we) last saw the deceased alive on | | 7-22-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE | | M.D. OEGREE | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | | 7-22-72 | |
| 23C. PHYSICIAN'S NAME (Type) | | M.D. OEGREE | | 23D. ADDRESS | | | | | |
| Dr. Mustaq Ahmad | | | | Maryland General Hospital | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| burial | | 7-26-72 | | Immanuel Lutheran Cem. | | Balto., Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| JUL 27 1972 | | Sidney H. Wilson | | Paul Heeman | | 6067 Harford Rd. | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| B-651 | | 72 07056 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07056 | |
| BIRTH NO. | | | | REG. NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | STATE OF MARYLAND - DHMH | | | |
| AUGUSTA M. BAUERNFEIND | | | | 2. DATE AND HOUR OF DEATH July 25, 1972 5:15 A. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE | | | |
| 90 Edith A Anderson Nursing Home 3604 Mohawk Ave. Balto., 21207, Md. | | | | Md. 2611 | | | |
| 5. SEX | | | | 6. RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| Female | | White | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| | | | | | | Apr. 3, 1891 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday) | |
| Retired | | | | Waitress | | 81 | |
| 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | 11. Under 1 Yr. Months: Days | |
| Baltimore, Md. | | | | U.S.A. | | 11. Under 24 Hrs. Hours: Min. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Henry Bauernfeind | | | | Margaret Rauh | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | | | 212-09-3365 | | ADDRESS | |
| | | | | Marie A. Doughney : | | Same. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.) | | | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| NOT A MEDICAL EXAMINER'S CASE (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.) | | | | (A) IMMEDIATE CAUSE | | - 5 yrs - | |
| DISEASE OR CONDITION EXAMINER giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | DUE TO, OR AS A CONSEQUENCE OF: | | 20 hours | |
| | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | Generalized Arterio Sclerosis | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| None | | None | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| None | | None | | None | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| None | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | None | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 10 1972 to July 25 1972 that (I) (we) last saw the deceased alive on July 24 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Earl L. Chambers Jr. | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| EARL L. CHAMBERS | | | | 100 W. Cold Spring Lane, Balto. 10, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 7-28-72 | | Sacred Heart Cemetery | | 7401 German Hill Rd. Ba. Co., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JUL 27 1972 | | Anthony M. Burton | | J. Charles J. Gailer | | 901 S. Conkling St. Balto., 21224, Md. | |



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7-500a T-46072 07057
STATE OF MARYLAND-DEMD
BALTIMORE CITY HEALTH DEPARTMENT

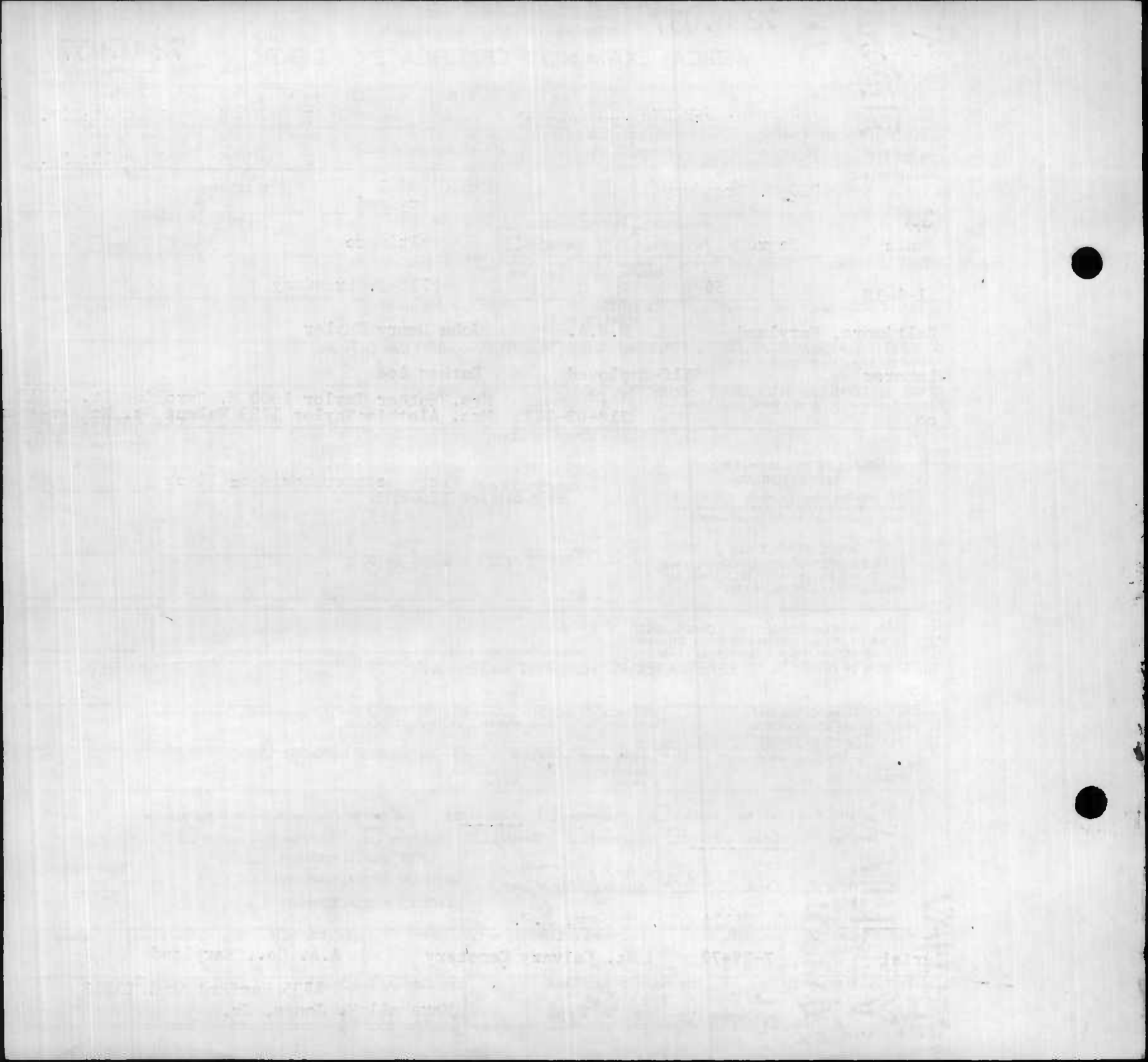
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07057

REG. NO.

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) John H. Taylor (John Henry Funnie) | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 7 25 72 12:23P.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1716 N. Broadway | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 25 72 12:23P.M. | |
| 6. SEX Male | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 806 | |
| 9. DATE OF BIRTH 1-4-18 | | 10. AGE (In years lost birthday) 54 | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Henry Taylor | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | |
| 15. MOTHER'S MAIDEN NAME Euther Lee | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | |
| 17. SOCIAL SECURITY NO. 218-03-2289 | | 18. INFORMANT Mrs. Euther Taylor 1603 N. Caroline St. 21213 Mrs. Alethia Taylor 1239 Walnut St. McKeesport, Penna. 15132 | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 7 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) Yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>William P. Mulloy</i> M.D. EXAMINER'S NAME (Type) William P. Mulloy, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-26-72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-29-72 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery | | 24D. LOCATION (City, town, or county) (State) A.A. Co., Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT JUL 27 1972 | | 25B. NAME OF REGISTRAR Sidney Johnson | |
| 25C. FUNERAL DIRECTOR 1735 Harford Ave. 21213 Marshall W. Jones, Jr. | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07058

REG. NO.

BIRTH NO.

| | | | |
|--|---|---|--|
| 1. NAME OF DECEASED (Type or Print) M. NORMAN KEMP Jr. | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> July 25, 1972 Hour: 8:06 P. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year July 25, 1972 Hour: 8:06 P. M. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2609 | | | |
| 6. SEX Male | 7. RACE White | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH Dec. 25, 1954 | | 10. AGE (in years last birthday) 17 | |
| 11. BIRTHPLACE (State or foreign country) Baltimore | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Norman M. Kemp Sr. | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broom Factory | |
| 15. MOTHER'S MAIDEN NAME Maxine Valentine | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT ADDRESS Norman M. Kemp Sr. 704 S. Baylis Street | |
| 19. E918X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Fracture of neck (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) Yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) factory | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Atlantic Southwestern Broom Co. | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 7-25-72 7:25 P. m. | |
| 22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? 1301 S. Baylis St. Caught head in elevator shaft | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Marvin S. Platt, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 26, 1972 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 7-29-1972 | 24C. NAME of CEMETERY or CREMATORY Sacred Heart Cemetery | 24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | 25B. NAME OF REGISTRAR Sidney [illegible] | 25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave. | |

Dec. 22, 1921

Baltimore

J. A.

Brook Society

Norman M. Kemp Jr.

Brook Society

Norman M. Kemp Jr. 7th & Davis Streets

No

Serial 100-1072

Serial 100-1072

Baltimore County, Maryland

1921-22

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07059 | |
|--|-------------------|--|---------------------------------|--|--|
| 72 07059 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. 72 07059 | | 1. NAME OF DECEASED (Type or Print) <u>Robert E. Anderson Sr.</u> | | | |
| 2. DATE AND HOUR OF DEATH <u>7/24/72</u> | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | |
| A. STATE <u>Md.</u> | | B. COUNTY <u>1504</u> | | | |
| C. CITY OR TOWN <u>Balto.</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER <u>1835 Walbrook Ave.</u> | | | | | |
| 6. SEX <u>M.</u> | 7. RACE <u>C.</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 9. DATE OF BIRTH <u>9-29-11</u> | 10. AGE (In years last birthday) <u>60</u> | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> |
| 12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEWART</u> | | 13. KIND OF BUSINESS OR INDUSTRY | | 14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 15. FATHER'S NAME <u>Robert E. Anderson Sr.</u> | | 16. MOTHER'S MAIDEN NAME <u>Rose Bundy</u> | | 17. INFORMANT <u>Paul Anderson-3228 Yosemite Ave.</u> | |
| 18. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 19. SOCIAL SECURITY NO. | | 20. ADDRESS | |
| 21. CAUSE OF DEATH | | 22. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | 23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial infarct</u> | | 24. ANTECEDENT CAUSES | | 25. 10 minutes | |
| (B) <u>Atherosclerosis</u> | | 26. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | 27. 39 yrs | |
| (C) <u>Hypertensive heart disease</u> | | 28. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | 29. 6 yrs | |
| 30. MEDICAL CERTIFICATION | | 31. 19A. DATE OF OPERATION | | 32. 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 33. 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 34. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 35. 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 36. 21D. TIME OF INJURY (APPROX.) | | 37. 21E. INJURY OCCURRED | | 38. 21F. HOW DID INJURY OCCUR? | |
| 39. 22. I certify that (I) (this hospital) attended the deceased from <u>Jan 1970</u> to <u>July 1972</u> , that (I) (we) lost saw the deceased alive on <u>7/23</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 40. 23A. SIGNATURE <u>G. C. Burwell M.D.</u> | | 41. 23B. DATE SIGNED <u>7/25/72</u> | |
| 42. 23C. PHYSICIAN'S NAME (Type) <u>A. C. BURWELL M.D.</u> | | 43. 23D. ADDRESS <u>1924 W. North Ave.</u> | | 44. 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | |
| 45. 24B. DATE <u>7-27-72</u> | | 46. 24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u> | | 47. 24D. LOCATION (City, town, or county) (State) <u>Westport, Md.</u> | |
| 48. 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 27 1972</u> | | 49. 25B. NAME OF REGISTRAR <u>Frederick H. Burton</u> | | 50. 25C. FUNERAL DIRECTOR <u>Edith Funeral Home-1129 N. Caroline St.</u> | |

W-623

BALTIMORE CITY HEALTH DEPARTMENT

72 07060

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07060

| | | | |
|---|--|--|--|
| BIRTH NO. 72 07060 | | REG. NO. 72 07060 | |
| 1. NAME OF DECEASED (Type or Print) <u>Junior Wright, (JUNIOR)</u> | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <u>7</u> Day <u>24</u> Year <u>72</u> Hour <u>8:35 p.</u> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>422 E. 23rd Street</u> | | 3. DATE PRONOUNCED DEAD Month <u>7</u> Day <u>24</u> Year <u>72</u> Hour <u>8:35 p.</u> M. | |
| 6. SEX <u>male</u> | | 7. RACE <u>Negro</u> | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN <u>Balto.</u> | |
| 9. DATE OF BIRTH <u>3-3-35</u> | | 10. AGE (In years last birthday) <u>37</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>S. Carolina</u> | | 12. CITIZEN OF <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James Wright Sr.</u> | | 14. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>none</u> | |
| 15. MOTHER'S MAIDEN NAME <u>Lillie Wells</u> | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT <u>Christine Chambers-422 E 23rd</u> | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Fatty metamorphosis of liver</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(B) DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(C) DUE TO, OR AS A CONSEQUENCE OF:</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION <u>0</u> | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) <u>yes</u> | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22D. TIME OF INJURY (APPROX.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Peter Lipkovic, M.D.</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <u>7-27-72</u> | |
| 24C. NAME OF CEMETERY or CREMATORY <u>Balto. Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 27 1972</u> | | 25B. NAME OF REGISTRAR <u>Sidney Whorton</u> | |
| 25C. FUNERAL DIRECTOR <u>Elbert Funeral Home</u> | | ADDRESS <u>11294</u> | |

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WASH. D. C.

OFFICE OF THE ASSISTANT SECRETARY

WASHINGTON, D. C.

RECEIVED

NOV 10 1954

TO THE SECRETARY

FROM THE ASSISTANT SECRETARY

SUBJECT: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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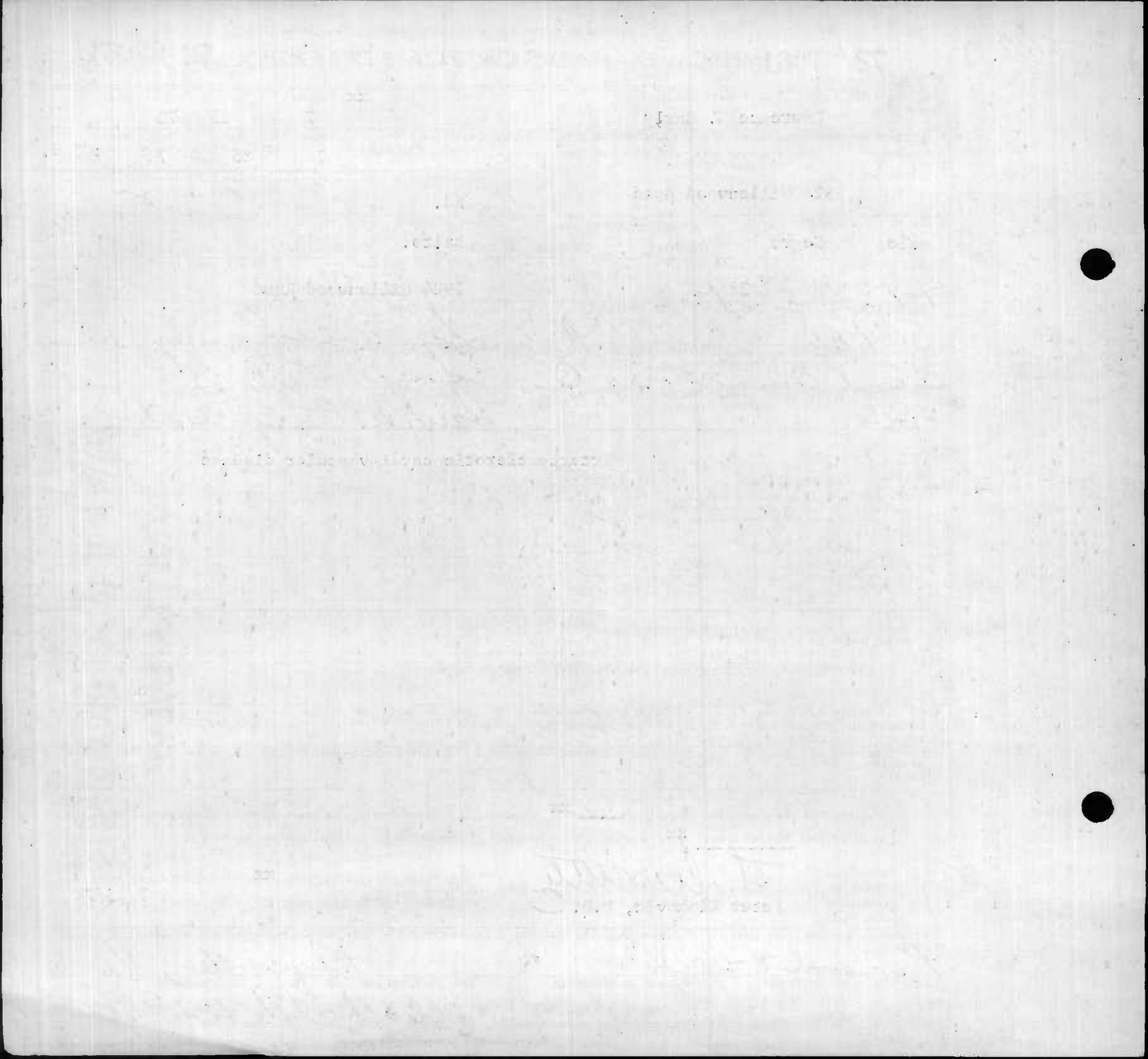
E-640¹

BALTIMORE CITY HEALTH DEPARTMENT

72 07061 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07061 REG. NO.

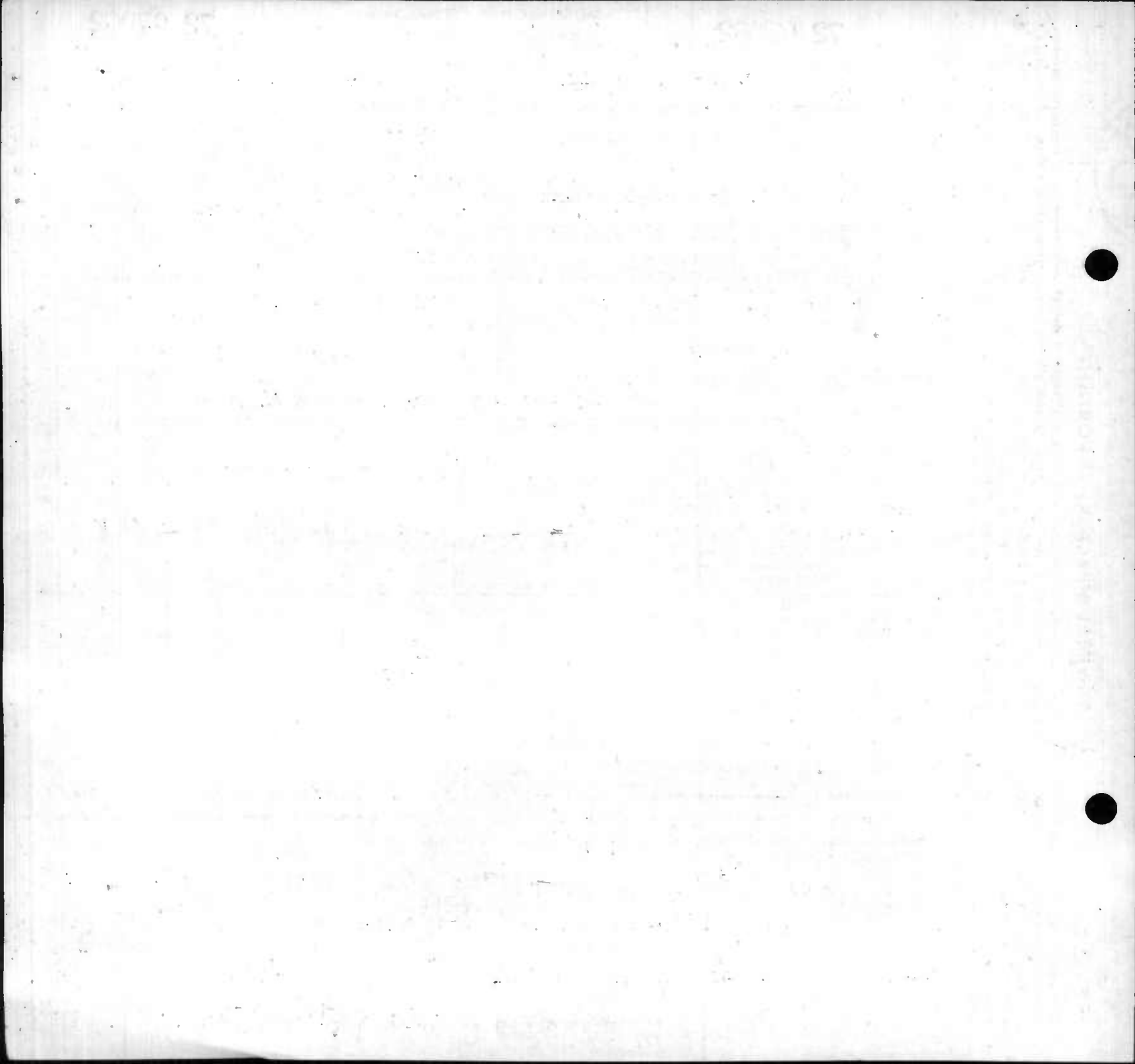
| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Lawrence E. Early | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 7 25 72 M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1924 Hillenwood Road | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 25 72 6:07 a. M. | |
| 6. SEX male | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 7. RACE Negro | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 4-15-35 | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 10. AGE (In years last birthday) 37 | | E. STREET AND NUMBER 1924 Hillenwood Road | |
| 11. BIRTHPLACE (State or foreign country) VA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Maker | | 15. MOTHER'S MAIDEN NAME Susie Lytle | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes | | 17. SOCIAL SECURITY NO. Harrell Early - 1924 Hillenwood Rd. | |
| 19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | 18. INFORMANT Harrell Early | |
| 20. DATE OF OPERATION 7-28-72 | | 21. AUTOPSY? (Yes or No) no | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME OF INJURY (APPROX.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type): Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 7/25/72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | | 24B. DATE 7-28-72 | |
| 24C. NAME OF CEMETERY or CREMATORY Keyserville, Va. | | 24D. LOCATION (City, town, or county) (State) Keyserville, Va. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Sidney Houston | |
| 25C. FUNERAL DIRECTOR Edwards J.H. | | 25D. ADDRESS 1129 N. Calhoun | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

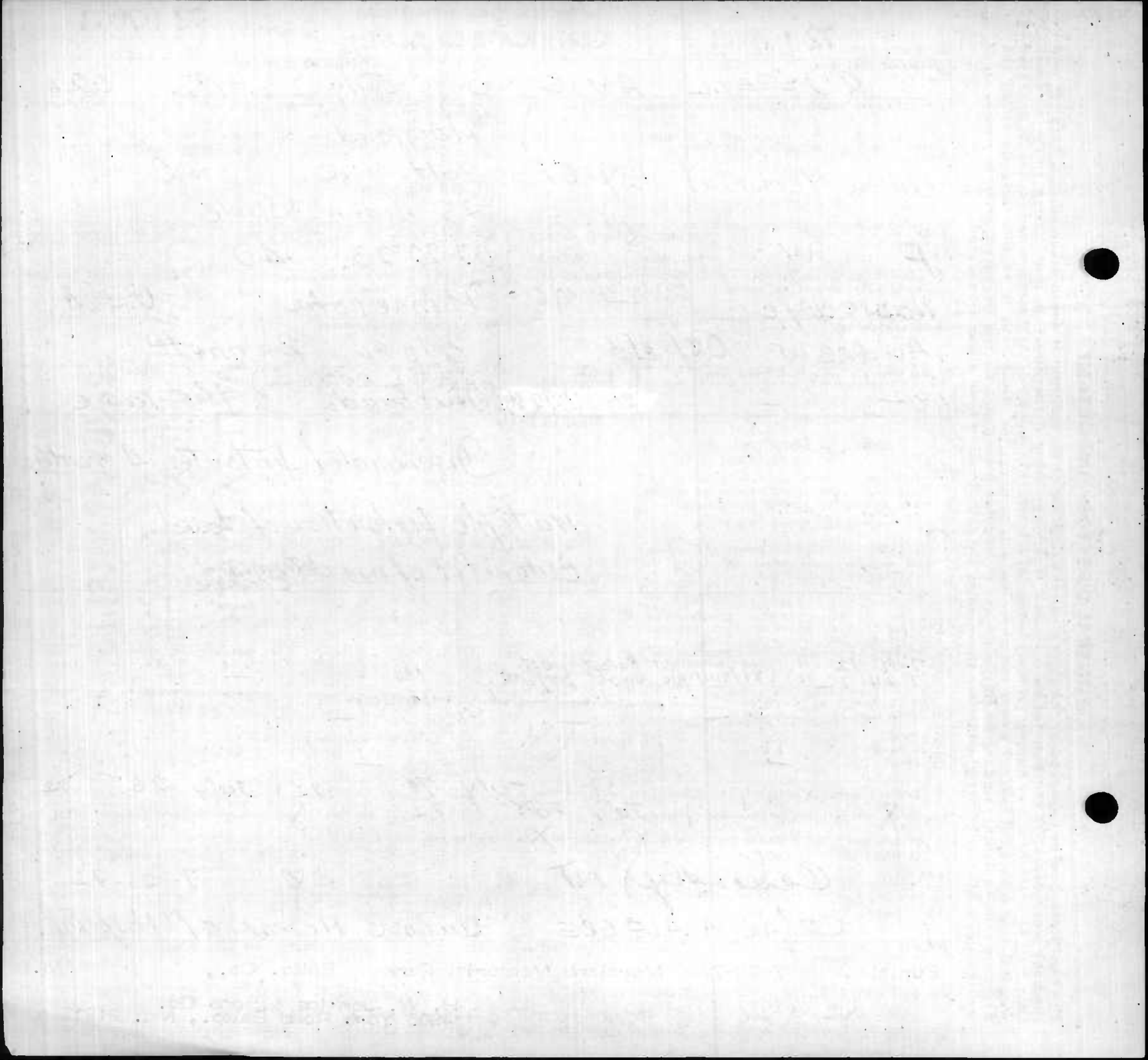
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07062 | |
|---|---|---|--|--|--|
| <div style="display: flex; justify-content: space-between;"> A-412 72 07062 CERTIFICATE OF DEATH </div> | | | | | |
| BIRTH STATE OF MARYLAND-DHMH NAME OF DECEASED (Type or Print) Mary E. Albaugh | | | 2. DATE AND HOUR OF DEATH July 26, 1972 7⁴⁵ A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 723 E. Cold Spring Lane | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 723 E. Cold Spring Lane 21212 | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-18-1878 | 9. AGE (In years last birthday) 94 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Edward Norris | | | 14. MOTHER'S MAIDEN NAME Emma King | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-48-0253 | 17. INFORMANT J-1 Mrs. Evelyn A. Hewitt | | ADDRESS Same |
| 18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF: | | 2 days |
| | | | (B) Arterio-sclerotic Vas Heart Dis DUE TO, OR AS A CONSEQUENCE OF: | | 12 yrs |
| | | | (C) _____ | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 24 1972 to July 26 1972, that (I) (we) last saw the deceased alive on July 24 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE Carl F. Benson M.D. | | | 23B. DATE SIGNED July 26 1972 Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | |
| 23C. PHYSICIAN'S NAME (Type) Carl F. Benson M.D. | | | 23D. ADDRESS 5111 York Road | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-29-72 | | 24C. NAME OF CEMETERY OR CREMATORY Park Meadowridge Memorial | |
| 24D. LOCATION (City, town, or county) Dorsey, | | 24E. STATE Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Audrey M. Horton | | 25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. | |
| | | | | ADDRESS 4905 York Road Balto., Md. 21212 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

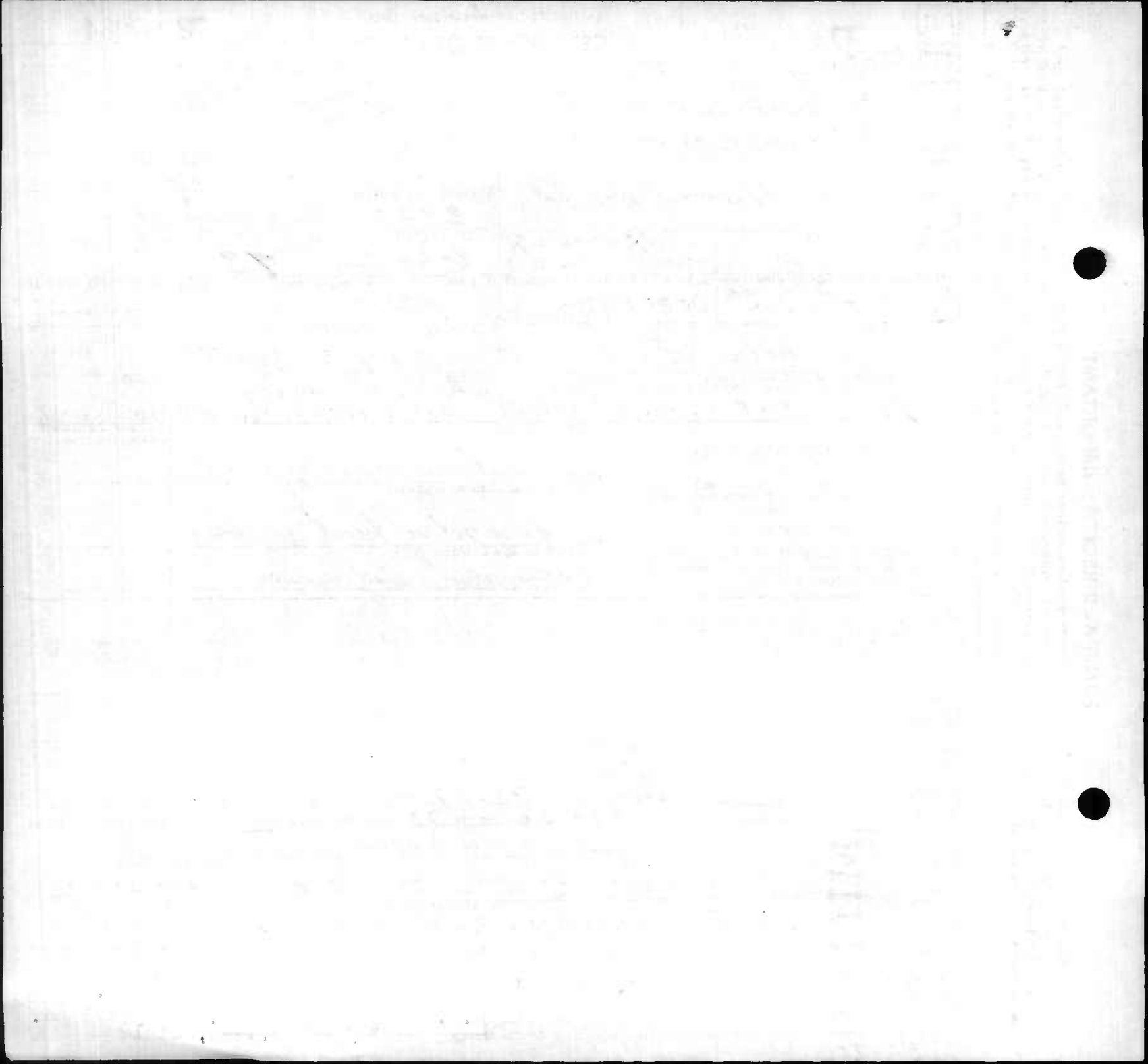
| BIRTH NO. <u>72 07063</u> | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. <u>72 07063</u> |
|--|------------------|--|----------------------------------|---|
| 1. NAME OF DECEASED (Type or Print) <u>RUSSELL, AVIS</u> | | 2. DATE AND HOUR OF DEATH <u>July 26th 1972 02A M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>29 Acorn circle</u> | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>07-22-23</u> | 9. AGE (In years last birthday) <u>49</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>OWN Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Minnesota</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Andrew Orfield</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Alpha Bennett</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | |
| 16. SOCIAL SECURITY NO. <u>476-18-1937</u> | | 17. INFORMANT <u>HARRY L. RUSSELL</u> (husband) ADDRESS <u>the same</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Disseminated peritonitis 4 months.</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Multiple perforation of bowel</u> (C) <u>Euteritis of non determined cause</u> | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION <u>7-11-72 (1)</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>(1) Ectopic obst.</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>July 7th 1972</u> to <u>July 26th 1972</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>July 26th 1972</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) (did not) view the body after death. | | |
| 23A. SIGNATURE <u>Cesar A. Legree</u> | | 23B. DATE SIGNED <u>7-26-72</u> | | 23C. PHYSICIAN'S NAME (Type) <u>CESAR A. LEGREE</u> |
| 23D. ADDRESS <u>Union Memorial Hospital</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | |
| 24B. DATE <u>7-28-72</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u> | | 24D. LOCATION (City, town, or county) (State) <u>Balto. Co., Md.</u> |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 27 1972</u> | | 25B. NAME OF REGISTRAR <u>Andrew Orfield</u> | | 25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u> ADDRESS <u>4905 York Road Balto., Md. 21212</u> |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

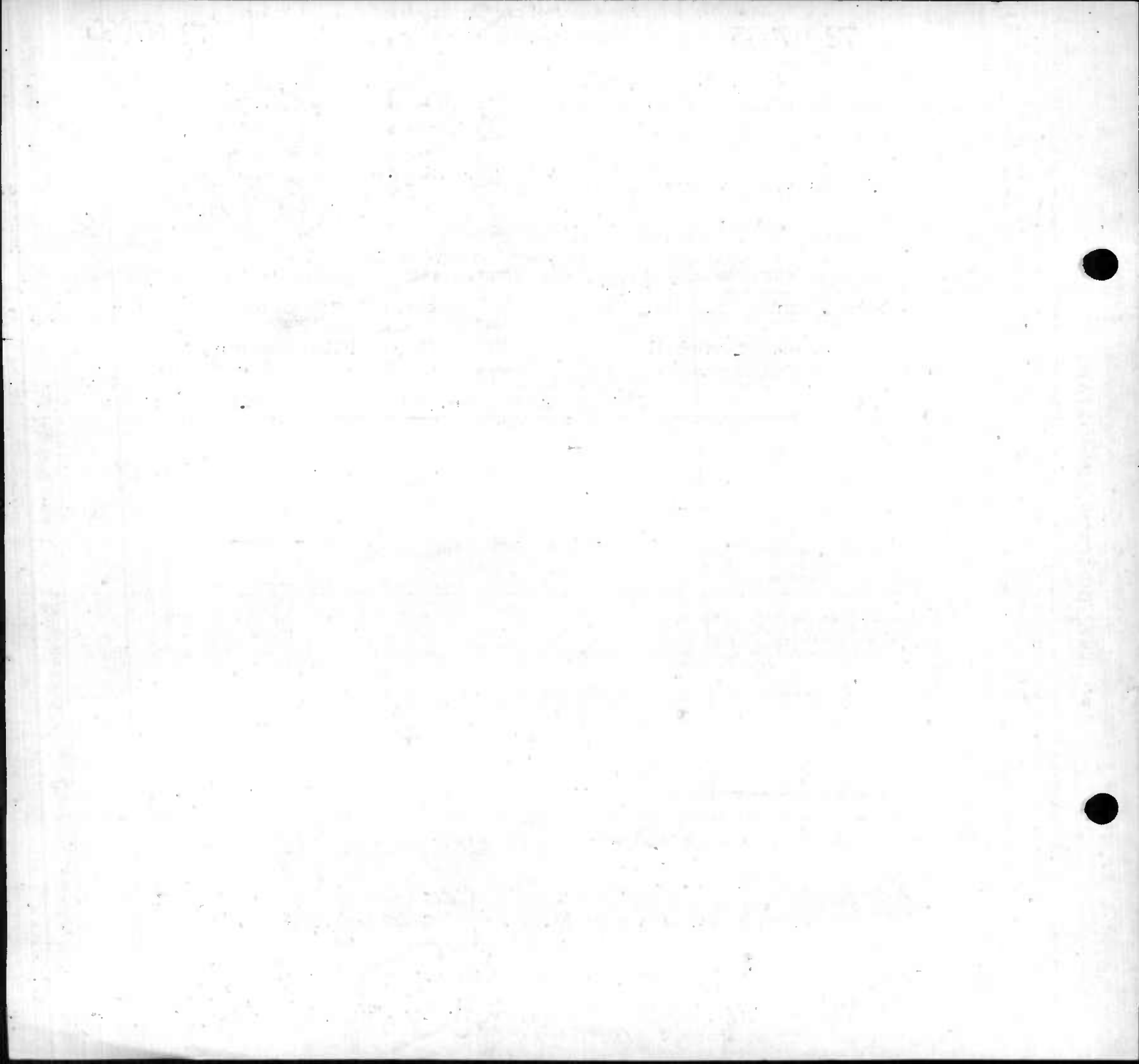
| | | | | | |
|--|------------------|--|------------------------------------|--|---|
| BIRTH NO. <u>72 07064</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. <u>72 07064</u> | |
| STATE OF <u>MARYLAND-DHMH</u> | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>THOMAS J. FORD</u> | | 2. DATE AND HOUR OF DEATH <u>7-26-1972</u> <u>1.35</u> P. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>The Union Memorial Hospital</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1206</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2820 Maryland Ave.</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-22-93</u> | 9. AGE (In years last birthday) <u>78</u> | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during life, if retired) <u>INVESTIGATOR</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>DEPT. MOTOR VEHICLES</u> | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Nicholas Ford</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Mary A. Scott</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u> | | | |
| 16. SOCIAL SECURITY NO. <u>218-36-87-50</u> | | 17. INFORMANT <u>MRS. ELIAS CHANEY</u> ADDRESS <u>213 TYRONE RD. ARMAUGH VALLEY</u> | | | |
| 18. <u>4/2.3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardio respiratory arrest</u> (B) <u>congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Arteriosclerotic heart disease</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Arteriosclerotic Cerebral Disease</u> | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>07-17-1972</u> to <u>07-26-1972</u> that (I) (we) last saw the deceased alive on <u>07-26-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Dr. E. Manyari, M.D.</u> | | 23B. DATE SIGNED <u>07-26-72</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Dr. E. Manyari, M.D.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>7/29/72</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's</u> | |
| 24D. LOCATION <u>Texas</u> | | 24E. NAME OF REGISTRAR <u>Andrew Johnson</u> | | 24F. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 27 1972</u> | | 25B. NAME OF REGISTRAR <u>Andrew Johnson</u> | | 25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u> | |
| 25D. ADDRESS <u>4905 York Rd.</u> | | 25E. ADDRESS <u>Baltimore, Md. 21212</u> | | 25F. ADDRESS <u>21212</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | REG. NO. 72 07065 |
|--|--|--|--|--|--|--|
| 72 07065 STATE OF MARYLAND-DHMH CERTIFICATE OF DEATH | | | | | | |
| BIRTH NO. 72 07065 | | 1. NAME OF DECEASED (Type or Print) John P. Campbell | | | | 2. DATE AND HOUR OF DEATH July 26, 1972 10 A M. |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 508 Radnor Avenue | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2710 | | | |
| 5. SEX M | | | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-15-1899 | 9. AGE (In years last birthday) 72 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Room | | | 10B. KIND OF BUSINESS OR INDUSTRY Hospital Balto. City | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 13. FATHER'S NAME Charles Campbell | | | 14. MOTHER'S MAIDEN NAME Lillian Hoffman | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 218-22-8950 | | 17. INFORMANT Mr. Richard Campbell | |
| 18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 15 19 70 to July 26 19 72 , that (I) (we) last saw the deceased alive on June 19 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | |
| 23A. SIGNATURE Donald R. Jandorf | | | 23B. DATE SIGNED 7-27-72 | | 23C. PHYSICIAN'S NAME (Type) Donald R. Jandorf M. D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 7-29-72 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | | 25B. NAME OF REGISTRAR Andrew Johnston | | 25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. | |
| | | | | | ADDRESS 14905 York Road Balto., Md. 21212 | |



I-4631

BALTIMORE CITY HEALTH DEPARTMENT

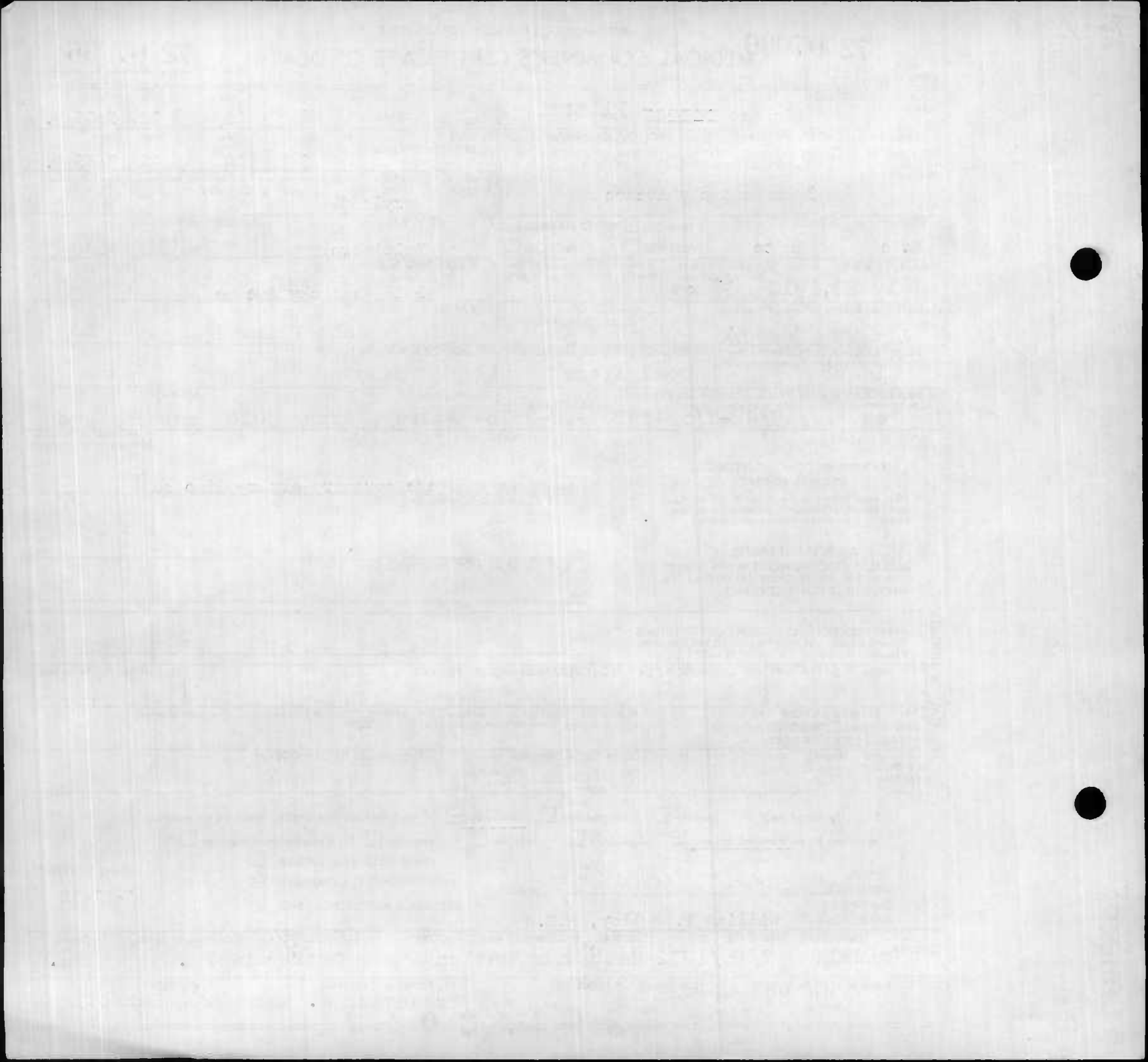
72 07066

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07066

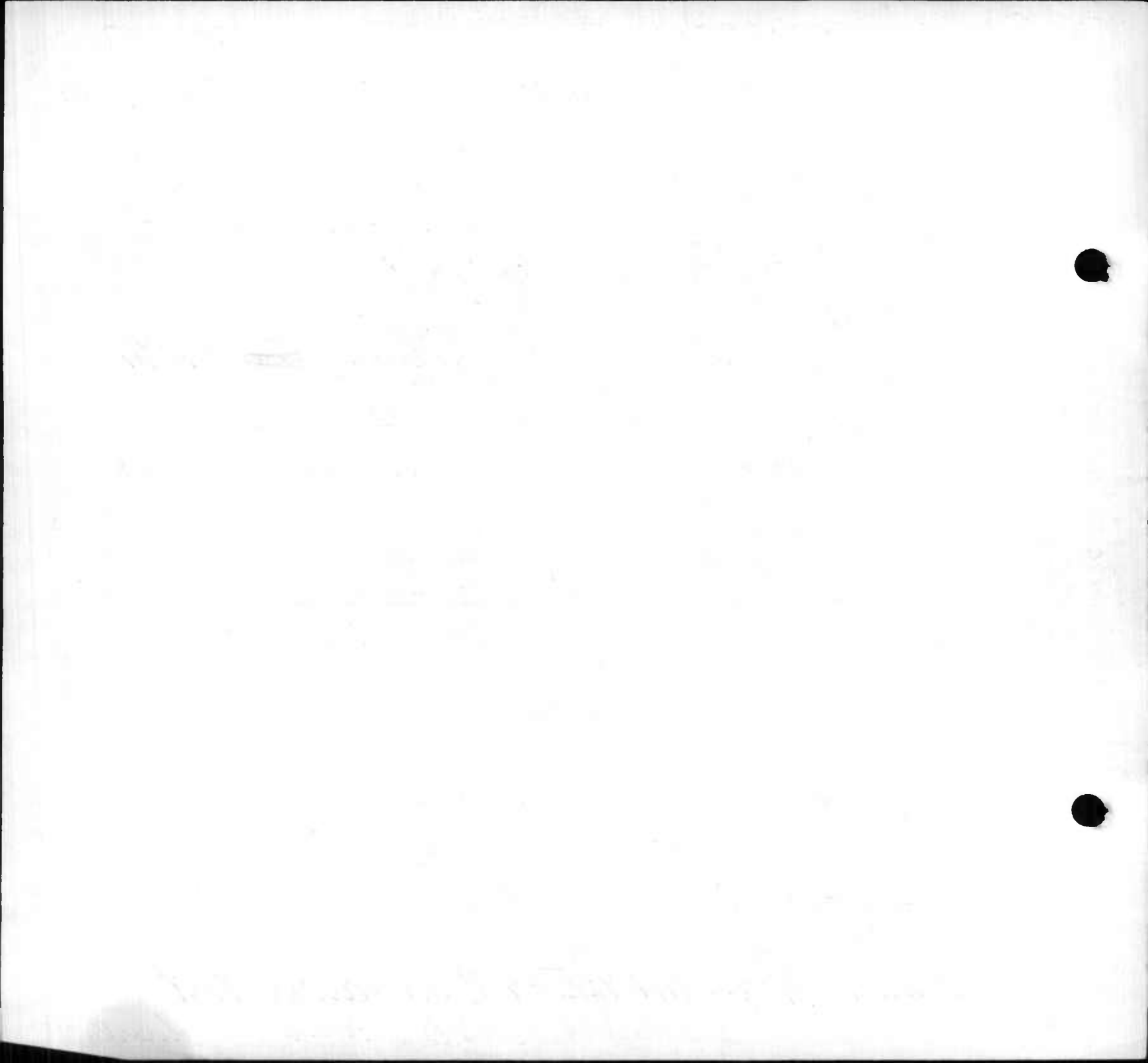
BIRTH NO. STATE OF MARYLAND DEATH

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Michael Illardi Illardi | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 7 Day 20 Year 72 Hour 3:45 P. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3016 Kentucky Avenue | | 3. DATE PRONOUNCED DEAD Month 7 Day 20 Year 72 Hour 3:45 P. M. | |
| 6. SEX Male | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2633 | |
| 9. DATE OF BIRTH July 20, 1910 | | 10. AGE (in years last birthday) 59 62 | |
| 11. BIRTHPLACE (State or foreign country) NEW YORK | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 14B. KIND OF BUSINESS OR INDUSTRY Book Store | |
| 15. MOTHER'S MAIDEN NAME Unknown | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 12/19/42-7/5/43 | |
| 17. SOCIAL SECURITY NO. 207-20-2376 | | 18. INFORMANT ADDRESS Audrey Werner 3016 Kentucky Ave | |
| 19. 412.31 CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE Severe coronary artery disease DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) William P. Mulloy, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED 7-21-72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/26/1972 | |
| 24C. NAME OF CEMETERY or CREMATORY Gettysburg National | | 24D. LOCATION (City, town, or county) (State) Gettysburg Pa. Pa. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Sydney H. Houston | |
| 25C. FUNERAL DIRECTOR Frederick J. Cook | | ADDRESS 7200 Harford RD | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

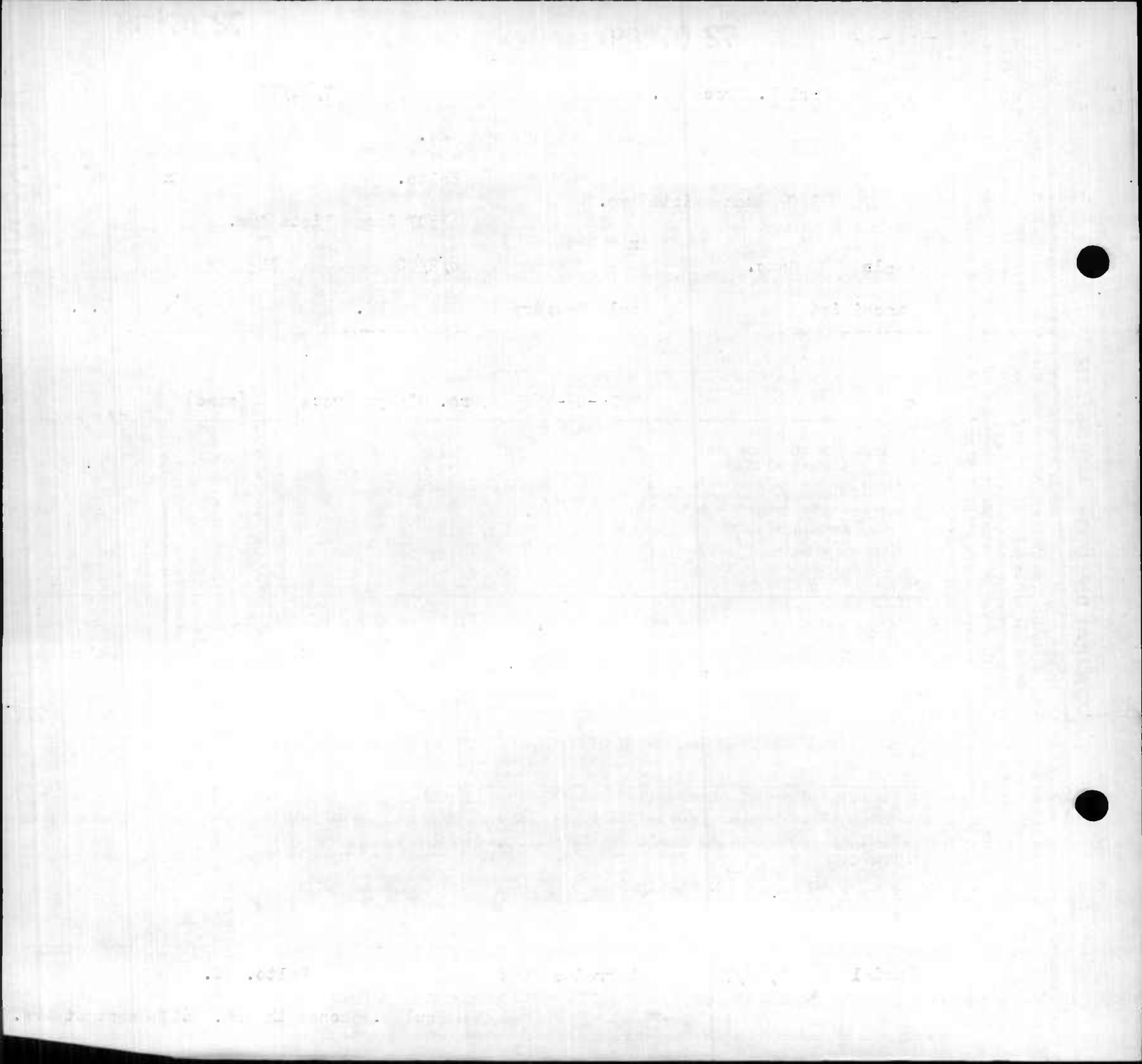
| 72 07067 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | REG. NO. 72 07067 | |
|--|-------------------------|---|--|---|--|---|--|
| BIRTH STATE OF MARYLAND - DEPT | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) BOWMAN, MARTHA | | | | 2. DATE AND HOUR OF DEATH 7-24-72 3 35 PM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 1606 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Gorge Washington N Home 607 PENNSYLVANIA AVE. 90 | | | | C. CITY OR TOWN Maryland | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 643 Roseale St. | | | |
| 5. SEX Female | 6. RACE Black | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH 3/8/1908 | 9. AGE (In years last birthday) 54 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodial | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Samuel James | | | | 14. MOTHER'S MAIDEN NAME Rebecca For Smith | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. unknown | | 17. INFORMANT Chart. | |
| 18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH EMPHYSEMA BULMOUS | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD | | 4 mos | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II Congestive Failure | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 13 MARCH 19 72 to 24 JULY 19 72 that (1) (we) last saw the deceased alive on 24 JULY 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Richard Tyson | | | | 23B. DATE SIGNED 24 July 72 | | 23C. PHYSICIAN'S NAME (Type) Richard Tyson, MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 7/28/72 | | 24C. NAME OF CEMETERY OR CREMATORY Old National Cem. Laurel Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | | | 25B. NAME OF REGISTRAR Robert W. Wilson | | 25C. FUNERAL DIRECTOR Richard H. 319 N. Snowden St | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

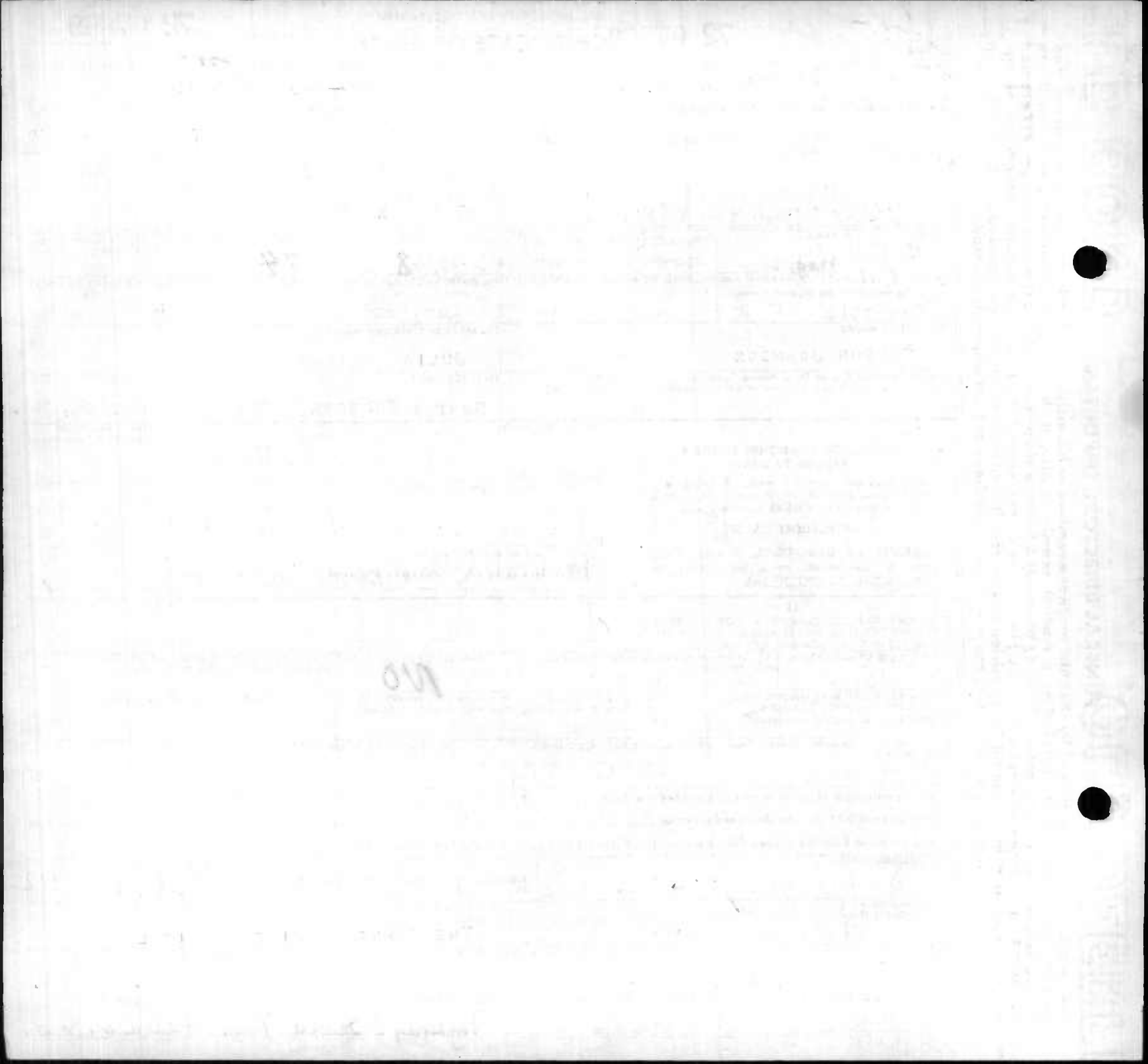
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07068 | |
|--|--|--|--|---|---|
| 72 07068 CERTIFICATE OF DEATH | | | | STATE OF MARYLAND-DHMH | |
| BIRTH NO. 7-620 | | 1. NAME OF DECEASED (Type or Print) Earl L. Frock Sr. | | | |
| 2. DATE AND HOUR OF DEATH 7/26/72 5 15 A.M. | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3507 Buena Vista Ave. | | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1348 | | C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER 3507 Buena Vista Ave. | | | | | |
| 5. SEX Male | 6. RACE Cauc. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8/2/00 | 9. AGE (In years last birthday) 71 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist | | 10B. KIND OF BUSINESS OR INDUSTRY Poole Foundry | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME ? | | | |
| 14. MOTHER'S MAIDEN NAME ? | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | |
| 16. SOCIAL SECURITY NO. 214-03-6523 | | 17. INFORMANT Mrs. Gladys Frock (same) ADDRESS | | | |
| 18. 162.1 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Lung ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized Atherosclerosis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year | | | |
| MEDICAL CERTIFICATION | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 19 64 to July 19 72 , that (I) (we) last saw the deceased alive on July 25 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Sheldon Goldberger DEGREE | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 7/28/72 | 24C. NAME OF CEMETERY OR CREMATORY Lorraine Park | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Sheldon Goldberger | | 25C. FUNERAL DIRECTOR Paul E. Ghenoweth 3rd. 3617 Chestnut Ave ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | 72 07069 | | CERTIFICATE OF DEATH | | REG. NO. 72 07069 | |
|--|-------------------------|---|--|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) <u>Susie Johnson</u> | | | | 2. DATE AND HOUR OF DEATH <u>7/24/72</u> <u>4:25 PM</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Johns Hopkins Hospital</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>CALVERT</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Johns Hopkins Hospital</u> | | | | C. CITY OR TOWN <u>PRINCE FREDERICK</u> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | E. STREET AND NUMBER <u>RT 1 Box 67</u> | | | |
| 5. SEX <u>BF</u> | 6. RACE <u>negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5/19/98</u> | 9. AGE (In years last birthday) <u>74</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | | | 13. FATHER'S NAME <u>BENSON JOHNSON</u> | | | | |
| 14. MOTHER'S MAIDEN NAME <u>JULIA Wallace</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT <u>George Johnson</u> ADDRESS <u>Prince Frederick, Md.</u> | | | | |
| 18. CAUSE OF DEATH <u>569.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Pneumonia</u> | | | | | | | |
| 19A. DATE OF OPERATION <u>7/18/72</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Bowel Obstruction</u> | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7/15</u> 19 <u>72</u> to <u>7/24</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>7/24</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>J. Lucian Davis, MD</u> | | | | 23B. DATE SIGNED <u>July 24, 1972</u> | | 23C. PHYSICIAN'S NAME (Type) <u>J. LUCIAN DAVIS</u> | |
| 23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u> | | | | 24A. BURIAL CREMATION, (REMOVAL) (Specify) <u>7/29/72</u> | | | |
| 24B. DATE <u>7/29/72</u> | | | | 24C. NAME of CEMETERY or CREMATORY <u>Brooks Church Cem</u> | | 24D. LOCATION (City, town, or county) (State) <u>Calvert Co., Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>11/1 27 1972</u> | | | | 25B. NAME OF REGISTRAR <u>Sidney Johnson</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Phyllis F. Snell Prince Frederick, Md.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | REG. NO. 72 07070 | |
|--|--|---|---|--|--|
| H-625 72 07070 CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Joseph Harrison | | July 22, 1972 10:00 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE B. COUNTY | | |
| Harbor View Nursing Home 1213 Light Street, Baltimore | | | Pr. Geo. 6600 | | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| Male | | Caucasian | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. BIRTHPLACE (State or foreign country) | |
| 1/29/1908 | | 64 | | Wash., DC | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | |
| Wash., DC | | U.S.A. | | Francis M. Harrison | |
| 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| Mary E. Otias | | No - | | 577-22-3623 | |
| 17. INFORMANT | | 18. CAUSE OF DEATH | | 19. MEDICAL CERTIFICATION | |
| Norman R. Harrison - above address - (Brother) | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic Bronchitis | |
| | | Myocardial Infarction | | | |
| | | Diabetes Mellitus and ASCVD | | | |
| 20. AUTOPSY? (Yes or No) | | 21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22. I certify that (I) (this hospital) attended the deceased from March 13 19 72 to July 22 19 72, that (I) (we) last saw the deceased alive on July 22 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 23A. SIGNATURE | |
| | | | | Peter H. Rheinsteen, M.D. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from March 13 19 72 to July 22 19 72, that (I) (we) last saw the deceased alive on July 22 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE | | 23B. DATE SIGNED | |
| | | Peter H. Rheinsteen, M.D. | | July 24, 1972 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | 24. BURIAL CREMATION, REMOVAL (Specify) | |
| Peter H. Rheinsteen, M.D. | | Harbor View Nursing Home | | Burial | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 7/26/1972 | | Wash. Nat. Cem. | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | |
| Suitland, Md. | | JUL 27 1972 | | Sidney Robinson | |
| 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | | 25E. ADDRESS | |
| Nalley's Funeral Home Inc. | | Mt. Rainier, Md. | | | |

11. Dec.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|----------------------|---|-----------------------------|--|---|---|---|
| 5-162 | | 72 07071 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07071 | |
| BIRTH NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) ELEANOR SPARZAK | | | | 2. DATE AND HOUR OF DEATH JULY 24, 1972 1:56 A. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL HOSPITAL 43 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1453 Hull St. 21230 | | | |
| 5. SEX FEMALE | 6. RACE CAUCASIAN | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-22-95 | 9. AGE (In years last birthday) 77 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | 11. BIRTHPLACE (State or foreign country) POLAND | 12. CITIZEN OF WHAT COUNTRY? UNITED STATES |
| 13. FATHER'S NAME PETER MICHALSKI | | | | 14. MOTHER'S MAIDEN NAME FRANCES ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213-14-8604 | | 17. INFORMANT John Sparzak | | ADDRESS 1453 Hull St. | |
| 18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) EXTENSIVE CEREBRAL VASCULAR ACCIDENT ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DIABETES MELLITUS | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 26 hrs. 10 yrs. 8 yrs. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). HYPERPYREXIA & POSSIBLE SEPTIS | | | | 24 hrs. | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that he (this hospital) attended the deceased from 7-23-1972-10:15 AM. to 7-24-1972 19 that he (we) last saw the deceased alive on 7-24-1972 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE July Tushoff, M.D. | | | | 23B. DATE SIGNED 7-24-1972 | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | |
| 23C. PHYSICIAN'S NAME (Type) JULIUS G. TOSHEFF, M.D. | | | | 23D. ADDRESS 2085 Woodbourne Ave, Baltimore, Md. 21239 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-27-72 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | 25B. NAME OF REGISTRAR Sidney [illegible] | | 25C. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc. | | ADDRESS 1501 EAST FORT AVENUE | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

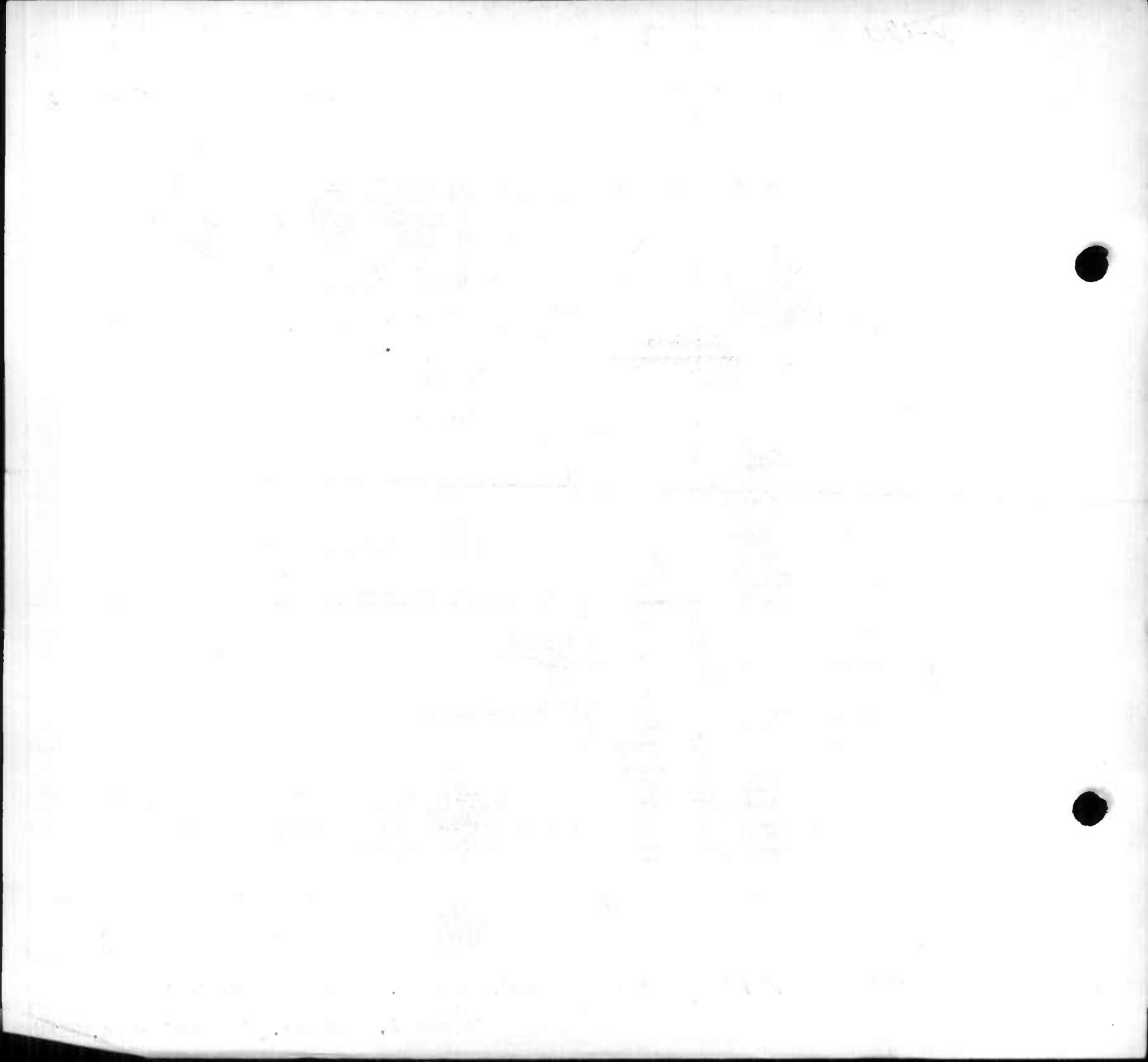
| | | | | |
|--|------------------|---|----------------------------------|--|
| BIRTH NO. M-420 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07072 |
| 1. NAME OF DECEASED (Type or Print) ALBERT C. MIELKE | | 2. DATE AND HOUR OF DEATH 7/24/72 3:00 AM. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GEN. HOSPITAL. 43 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE CITY. C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1461 TOWSON ST. | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-28-25 | 9. AGE (In years last birthday) 46 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic | | 10B. KIND OF BUSINESS OR INDUSTRY HEATING SPECIALTIES, INC. | | 11. BIRTHPLACE (State or foreign country) BALTIMORE |
| 13. FATHER'S NAME ALBERT C. MIELKE | | 14. MOTHER'S MAIDEN NAME MARY EDELL | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 212-22-6124 | | 17. INFORMANT WIFE |
| 18. 410.9 I + 162.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCT POSS. PULMONARY HYPERTENSION PROGRESSIVE HEART FAILURE POSS. CANCER OF LUNG. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (H) (this hospital) attended the deceased from 7-19-1972 to 7/24/1972 , that (H) (we) lost saw the deceased alive on 7/24/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE [Signature] | | | | 23B. DATE SIGNED |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS [Signature] | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/27/72 | | 24C. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial Gardens |
| 24D. LOCATION Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. JUL 27 1972 | | |
| 25B. NAME OF REGISTRAR [Signature] | | 25C. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc. | | |
| 25D. ADDRESS 3061501 East Fort Avenue | | | | |

2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|--|--|--|---|--|--|--|
| D-120 | | 72 07073 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07073 | |
| CERTIFICATE OF DEATH | | | | STATE OF MARYLAND-DHMH | | | |
| 1. NAME OF DECEASED (Type or Print) MRS. DOUGLAS N DAVIS | | | | 2. DATE AND HOUR OF DEATH 7-27-72 4 05 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME & HOSPITAL, BALTO, md. 35 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2744 | | | |
| 5. SEX F 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH 09-22-89 9. AGE (in years last birthday) 82 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) VIRGINIA | |
| 13. FATHER'S NAME Frederick Northup | | | | 14. MOTHER'S MAIDEN NAME LEAFIE LOWERY | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS HOSPITAL Records. | |
| 18. 156.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE LIVER FAILURE DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Pneumonia, @ Lung. | | | | | | | |
| 19A. DATE OF OPERATION 7-21-72 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Diagnosis | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) None | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-15-72 19 to 7-27-72 19 that (I) (we) last saw the deceased alive on 7-27-72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Bernard Yukna MD | | | | 23B. DATE SIGNED 7-27-72 | | 23C. PHYSICIAN'S NAME (Type) BERNARD YUKNA MD | |
| 23D. ADDRESS CHURCH HOME & HOSPITAL, BALTO MD. | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/29/72 | | 24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR Henry Johnson | | 25C. FUNERAL DIRECTOR ADDRESS Leonard K. Ruok Inc. 5305 Harford Rd. | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07074
REG. NO.

BIRTH NO.

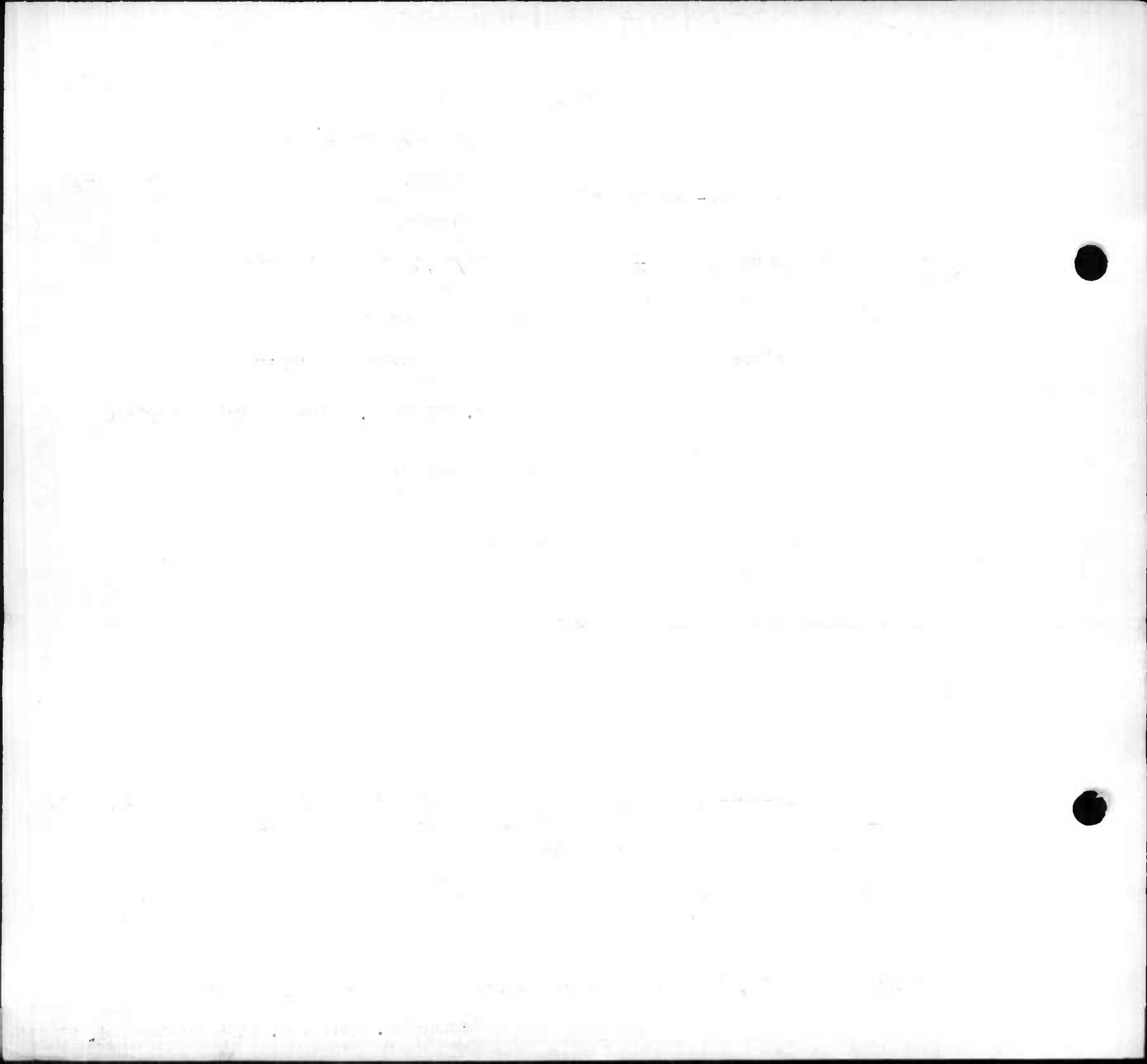
| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Darlene Denise Graves Prodey | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 7 Day 26 Year 72 Hour M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital | | 3. DATE PRONOUNCED DEAD Month 7 Day 26 Year 72 Hour 6:20 a. M. | |
| 6. SEX female | | 7. RACE White | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 7/26/1953 | | 10. AGE (In years last birthday) 19 | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT Charles J. Prodey Sr. | | ADDRESS same | |
| 19. 2812.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Traumatic subarchnoid hemorrhage CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ROAD | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 5100 blk. York Road 2711 | | 22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 7 26 72 3:40 a. m. | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Subject passenger in auto which struck parked car. | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/26/72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/29/72 | |
| 24C. NAME of CEMETERY or CREMATORY Loudon Park | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR A. J. [Signature] | |
| 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. | | ADDRESS Balto. Md. | |

• 2003

FUNERAL DIRECTOR: IMPORTANT

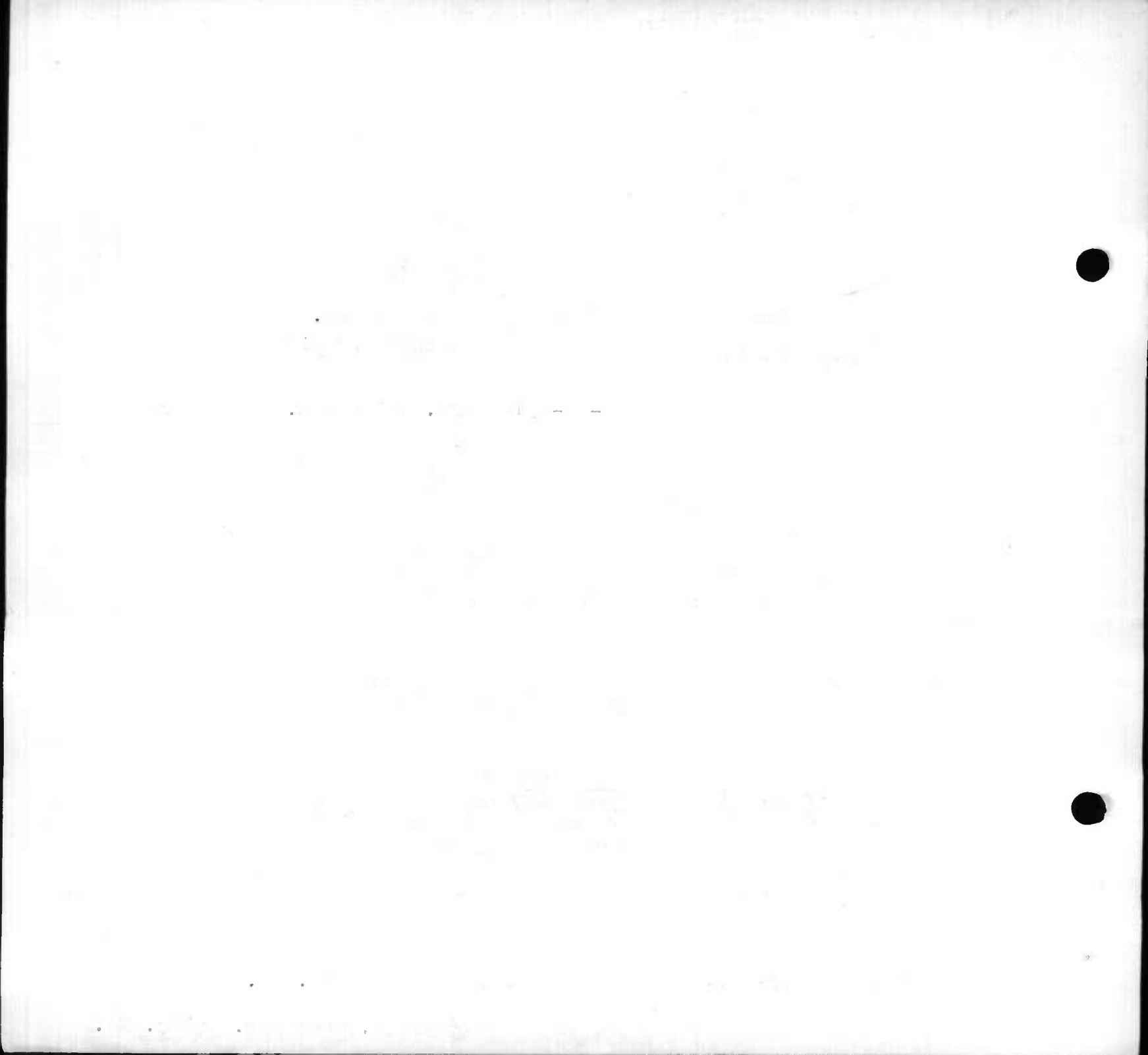
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|---------------------------------|---|--|
| <p style="font-size: 24pt; margin: 0;">G-300</p> <p style="font-size: 24pt; margin: 0;">72 07075</p> <p style="font-size: 12pt; margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 18pt; margin: 0;">CERTIFICATE OF DEATH</p> | | <p style="font-size: 24pt; margin: 0;">72 07075</p> <p style="font-size: 12pt; margin: 0;">REG. NO. STATE OF MARYLAND-DHMH</p> | |
| <p>BIRTH NO. _____</p> <p>1. NAME OF DECEASED (Type or Print) <u>MARGARET GAERE</u></p> | | <p>2. DATE AND HOUR OF DEATH <u>7/26/72</u> <u>3 45</u> P.M.</p> | |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><u>90 House in the Pines-Belair Road</u></p> | | <p>4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)</p> <p>A. STATE B. COUNTY</p> <p><u>District of Columbia</u> <u>V-48</u></p> <p>C. CITY OR TOWN D. INSIDE CITY LIMITS?</p> <p><u>Washington</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>E. STREET AND NUMBER</p> <p><u>Unknown</u></p> | |
| <p>5. SEX <u>Female</u></p> | <p>6. RACE <u>Caucasian</u></p> | <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p><u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/></p> | <p>8. DATE OF BIRTH <u>11/16/1887</u></p> <p>9. AGE (in years last birthday) <u>84</u> <u>83</u></p> <p>10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.</p> |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><u>Typist</u></p> | | <p>10B. KIND OF BUSINESS OR INDUSTRY</p> <p><u>Federal Government</u></p> | |
| <p>11. BIRTHPLACE (State or foreign country)</p> <p><u>Maryland</u></p> | | <p>12. CITIZEN OF WHAT COUNTRY?</p> <p><u>USA</u></p> | |
| <p>13. FATHER'S NAME</p> <p><u>Joseph Rabenau</u></p> | | <p>14. MOTHER'S MAIDEN NAME</p> <p><u>Katie Unknown</u></p> | |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p><u>No</u></p> | | <p>16. SOCIAL SECURITY NO.</p> <p>17. INFORMANT ADDRESS</p> <p><u>Mr. Milton O. Price Hydes Maryland</u></p> | |
| <p>18. <u>4/23/1</u> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF: <u>6 hours</u></p> <p>(B) <u>Chronic Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>yes</u></p> <p>(C) _____</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> <p><u>Chronic Bronchitis</u></p> | | | |
| <p>19A. DATE OF OPERATION</p> <p><u>0</u></p> | | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> | |
| <p>20A. AUTOPSY? (Yes or No)</p> <p><u>0</u></p> | | <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p> <p><input type="checkbox"/></p> | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p> | |
| <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | | <p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p> | |
| <p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | | <p>21F. HOW DID INJURY OCCUR?</p> | |
| <p>22. I certify that (I) (the hospital) attended the deceased from <u>7/27/1972</u> to <u>7/26/1972</u> that (I) (we) last saw the deceased alive on <u>7/24/1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | | | |
| <p>23A. SIGNATURE</p> <p><u>Alfred B. Brindley</u></p> | | <p>23B. DATE SIGNED</p> <p><u>7/26/72</u></p> | |
| <p>23C. PHYSICIAN'S NAME (Type)</p> <p><u>Alfred B. Brindley</u></p> | | <p>23D. ADDRESS</p> <p>DEGREE</p> <p>Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></p> | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p><u>Burial</u></p> | | <p>24B. DATE</p> <p><u>7/28/72</u></p> | |
| <p>24C. NAME of CEMETERY or CREMATORY</p> <p><u>Loudon Park Cemetery</u></p> | | <p>24D. LOCATION (City, town, or county) (State)</p> <p><u>Baltimore Maryland</u></p> | |
| <p>25A. DATE REC'D BY HEALTH DEPT.</p> <p><u>JUL 28 1972</u></p> | | <p>25B. NAME OF REGISTRAR</p> <p><u>Alfred B. Brindley</u></p> | |
| <p>25C. FUNERAL DIRECTOR</p> <p><u>Leonard J. Rack Inc.</u></p> | | <p>ADDRESS</p> <p><u>5305 Harford Rd. 21 214</u></p> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| <p>BIRTH NO. 14-160 72 07076 BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 1.2em; font-weight: bold;">CERTIFICATE OF DEATH</p> | | <p>REG. NO. 72 07076 STATE OF MARYLAND-DMH</p> | |
| <p>1. NAME OF DECEASED (Type or Print) <u>JOSEPH HENRY HUBER</u></p> | | <p>2. DATE AND HOUR OF DEATH <u>7-26-72</u> <u>10 30 AM</u></p> | |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>47 - North Charles St - Hospital</u> <u>2724 N Charles St</u></p> | | <p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Baltimore</u> B. COUNTY <u>2745</u></p> <p>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>Maryland</u></p> | |
| <p>5. SEX <u>M</u></p> | <p>6. RACE <u>W</u></p> | <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> | <p>8. DATE OF BIRTH <u>3-1-1897</u> 9. AGE (In years last birthday) <u>75</u></p> |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stuffer Crown</u></p> | | <p>10B. KIND OF BUSINESS OR INDUSTRY <u>Cash & Seal</u></p> | <p>11. BIRTHPLACE (State or foreign country) <u>Balto Md.</u></p> |
| <p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p> | | <p>13. FATHER'S NAME <u>George Huber</u></p> | |
| <p>14. MOTHER'S MAIDEN NAME <u>Anna Sperlein</u></p> | | <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u></p> | |
| <p>16. SOCIAL SECURITY NO. <u>212-12-6312</u></p> | | <p>17. INFORMANT <u>Mrs. Dolores M. Huber same</u></p> | |
| <p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>CAUSE OF DEATH <u>Septic Shock</u></p> | | <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> | |
| <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p><u>Urinary tract Infection, CVA</u></p> | | <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p><u>CVA</u></p> | |
| <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> | | <p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p> | |
| <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> | | | |
| <p>19A. DATE OF OPERATION <u>7-10-72</u></p> | | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> | |
| <p>20A. AUTOPSY? (Yes or No) <u>no</u></p> | | <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p> | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p> | |
| <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | | <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p> | |
| <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | | <p>21F. HOW DID INJURY OCCUR?</p> | |
| <p>22. I certify that (1) (this hospital) attended the deceased from <u>7-10-72</u> to <u>7-26-72</u> and that (1) (we) lost saw the deceased alive on <u>7-26-72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | | | |
| <p>23A. SIGNATURE <u>[Signature]</u></p> | | <p>23B. DATE SIGNED <u>7-26-72</u></p> | |
| <p>23C. PHYSICIAN'S NAME (Type) <u>[Signature]</u></p> | | <p>23D. ADDRESS</p> | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p> | | <p>24B. DATE <u>7/29/72</u></p> | |
| <p>24C. NAME of CEMETERY or CREMATORY <u>Gardens of Faith</u></p> | | <p>24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u></p> | |
| <p>25A. DATE REC'D BY HEALTH DEPT. <u>JUL 28 1972</u></p> | | <p>25B. NAME OF REGISTRAR <u>[Signature]</u></p> | |
| <p>25C. FUNERAL DIRECTOR <u>Leonard J. Buck Inc.</u></p> | | <p>ADDRESS <u>Balto. Md.</u></p> | |



N-600

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07077
REG. NO.

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) John Neary | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 2817 Orleans St. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 22 72 11:20 a. | |
| 6. SEX male | | 7. RACE White | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 3/22/08 | | 10. AGE (In years lost birthday) 66 64 | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME JOHN | | 14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 601 | |
| 15. MOTHER'S MAIDEN NAME FISCHER, KATIE | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 17. SOCIAL SECURITY NO. 218-12-6211 | | 18. INFORMANT ADDRESS MRS L. NEARY 3103 BRENDAN AVE | |
| 19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) no | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/23/72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION | | 24B. DATE 7/26/72 | |
| 24C. NAME of CEMETERY or CREMATORY GREEN MOUNT CEM. | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR Lidney Wharton | |
| 25C. FUNERAL DIRECTOR B DABROWSKI | | 25D. ADDRESS 2818 E. BALTO. ST. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|---|---|---|---|
| M-210 | | 72 07078 | | CERTIFICATE | |
| BIRTH NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) MOCKABEE, MARY L. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION GOOD SAMARITAN HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased) A. STATE MD. B. COUNTY JULY | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 147 N. LINWOOD AVE. | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-14-1890 | 9. AGE (In years last birthday) 82 | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MD. |
| 13. FATHER'S NAME WILLIAM BIRTHISTLE | | | 14. MOTHER'S MAIDEN NAME MARY ANN HALL | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT SON - Lloyd MOCKABEE |
| 18. 713.01 | | | CAUSE OF DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | (A) IMMEDIATE CAUSE PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF: | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) CHRONIC DEBRILITATION DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | (C) OSTEOARTHRITIS | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WEEK | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from FEB-15 19 72 to JULY 23 19 72 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JULY 23 19 72 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Michael Colvin, MD | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) MICHAEL COLVIN MD | | | | 23D. ADDRESS GOOD SAMARITAN HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 7-26-72 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem. | |
| 24D. LOCATION BALTO. MD. | | 24E. LOCATION (City, town, or county) | | 24F. LOCATION (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR Andrew Johnston | | 25C. FUNERAL DIRECTOR B. Dabrowski 244 E. Balto. St. | |

More photos of the same

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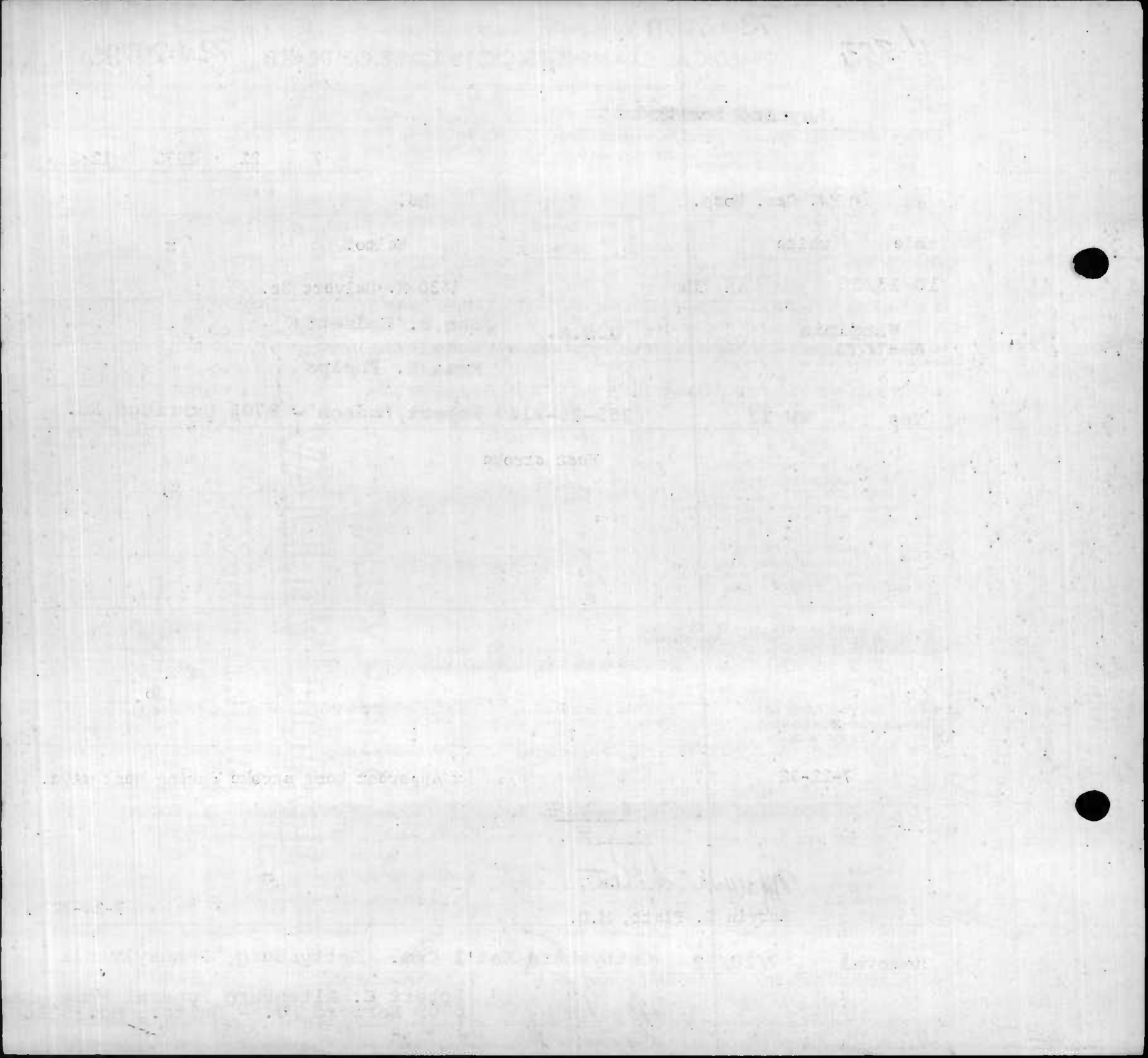
1st N. Avenue Ave.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH


72 07079
REG. NO.

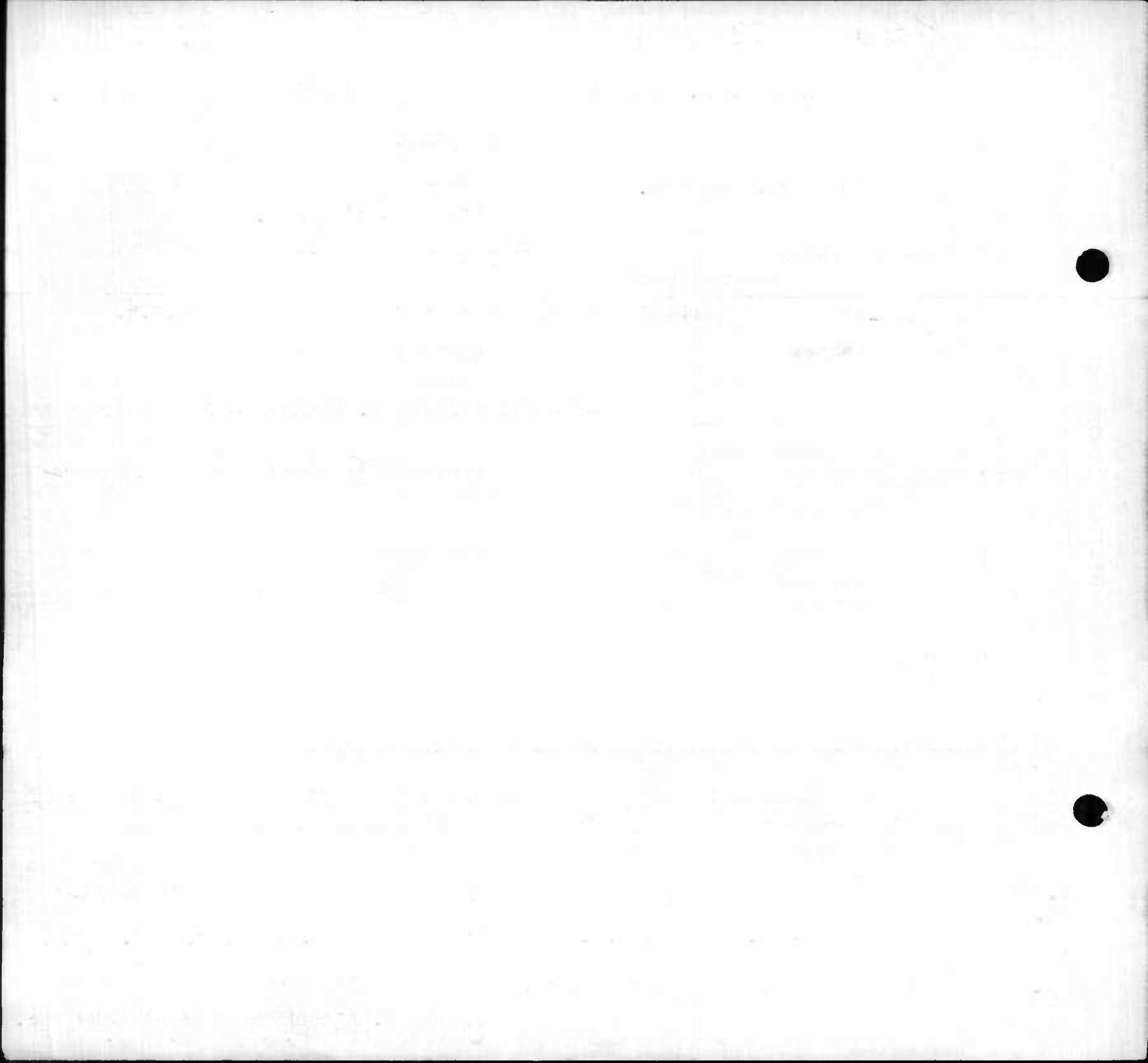
BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Raymond Lee Hodnett | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 Md. Gen. Hosp. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 22 1972 12:45p.m. | |
| 6. SEX male | | 7. RACE white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 10/15/26 | | 10. AGE (In years lost birthday) 45 | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II | | 17. SOCIAL SECURITY NO. 255-26-9149 | |
| 18. INFORMANT Robert Hudson | | ADDRESS 9703 Uxbridge Rd. | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E900X Heat stroke | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ? | |
| 22D. TIME OF INJURY (APPROX.) 7-22-72 ? m. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 22C. WHERE DID INJURY OCCUR? ? | | 22F. HOW DID INJURY OCCUR? Apparent heat stroke during heat wave. | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Marvin S. Platt EXAMINER'S NAME (Type) Marvin S. Platt, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | | 24B. DATE 7/28/72 | |
| 24C. NAME OF CEMETERY or CREMATORY Gettysburg Nat'l Cem. | | 24D. LOCATION (City, town, or county) (State) Gettysburg, Pennsylvania | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR Sidney [illegible] | |
| 25C. FUNERAL DIRECTOR Robert C. Altenburg Funeral Home, Inc. | | ADDRESS 6009 Harford Rd. - Balto., Md. 21214 | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

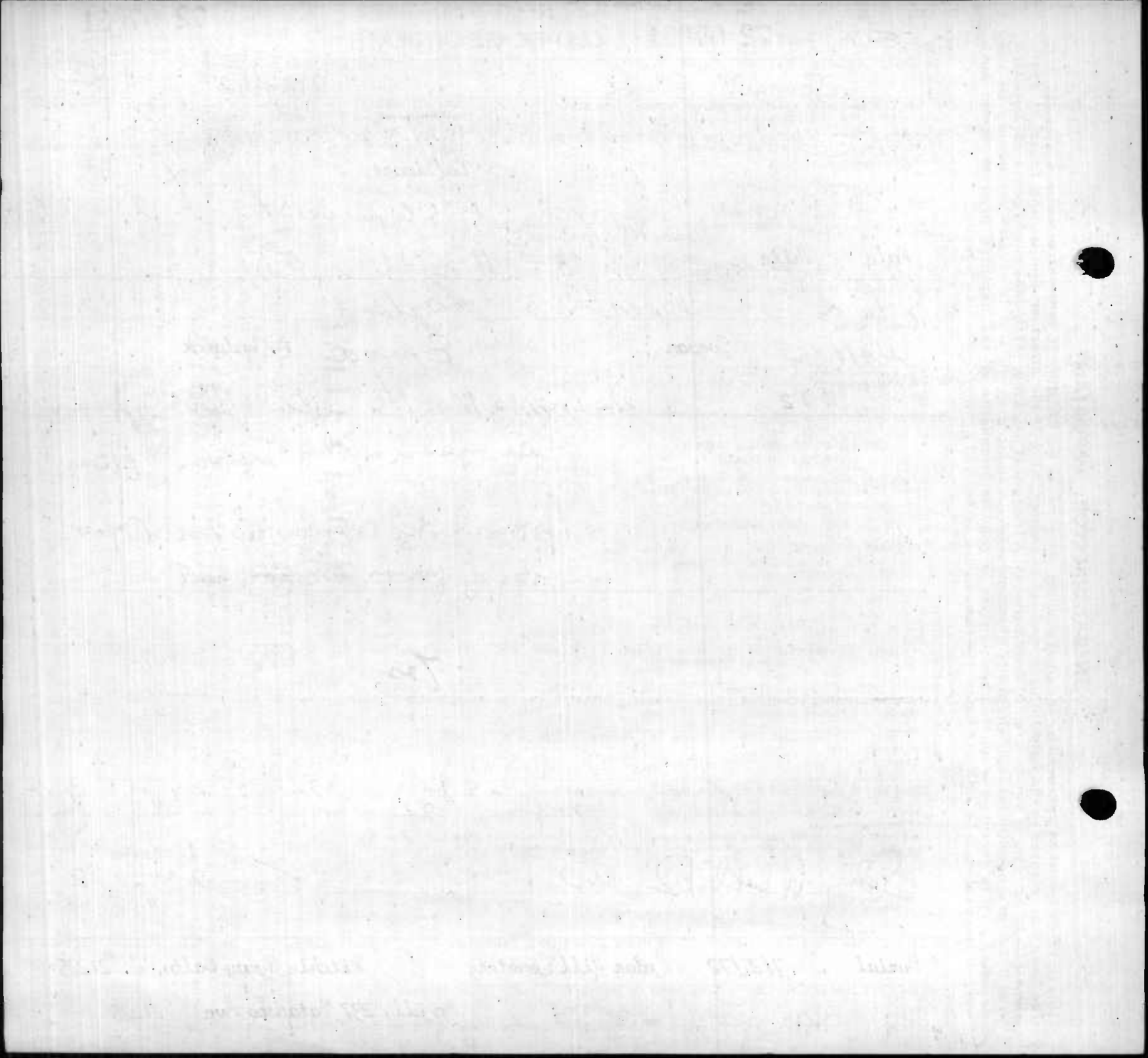
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07080 | |
|---|-------------------------|---|--|--|---|
| 72 07080 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. K-560 | | 1. NAME OF DECEASED (Type or Print) Lillian M. Keehner | | 2. DATE AND HOUR OF DEATH 7/24/72 8:00 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3006 Woodring Ave. | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2735 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3006 Woodring Ave. | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/14/1897 | 9. AGE (in years last birthday) 75 | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY School teacher | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME John Keehner | | | 14. MOTHER'S MAIDEN NAME Catherine Fritz | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-40-4558 | | 17. INFORMANT Lillian M. Keehner -3006 Woodring Ave. | |
| 18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic heart disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from March 14 1950 to July 24 1972 that (I) (we) last saw the deceased alive on July 24 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE  Edward J. Alessi, M.D. | | | 23B. DATE SIGNED 7/26/72 | | 23C. PHYSICIAN'S NAME (Type) Edward J. Alessi, M.D. |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/28/72 | | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | |
| 24D. LOCATION Baltimore | | 24E. ADDRESS 6217 Harford Rd. - Balto., Md. 21214 | | 24F. ADDRESS 6217 Harford Rd. - Balto., Md. 21214 | |
| 25A. DATE RECD BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR Robert C. Altenburg | | 25C. FUNERAL DIRECTOR Robert C. Altenburg Funeral Home Inc. 6009 Harford Rd. - Balto., Md. 21214 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

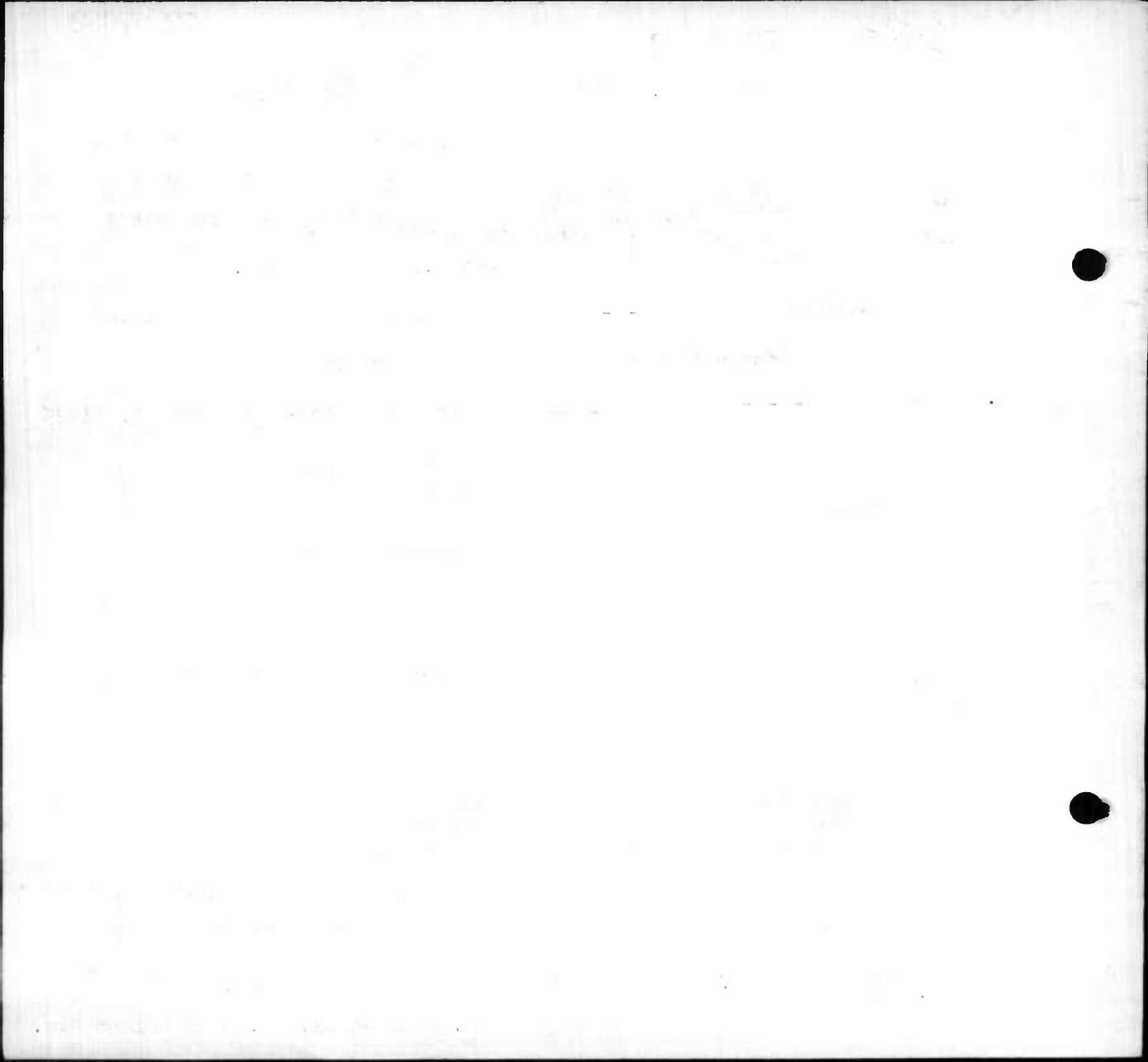
| | | | | | | | |
|---|--|--|--|--|--|--|--|
| <div style="display: flex; justify-content: space-between;"> J-635 72 07081 </div> | | BIRTH NO. 72 07081 | | CERTIFICATE OF DEATH | | REG. NO. 72 07081 | |
| 1. NAME OF DECEASED (Type or Print) JORDAN, Elmer | | | | 2. DATE AND HOUR OF DEATH 7/24/72 6:30 A M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 43 SOUTH BALTIMORE GEN. Hosp. (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 2505 5. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1505 Cypress St. 21226 | | | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11-30-21 | |
| 9. AGE (In years last birthday) 50 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Walter Jordan | | | | 14. MOTHER'S MAIDEN NAME Emma M. Undutch | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) WW 2 | | | | 16. SOCIAL SECURITY NO. 212-14-9134 | | 17. INFORMANT Myrtle wife 1505 Cypress St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 410.9 I Acute myocardial infarction - hypotension 6 hours | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: As known arterio cardiovascular disease (B) DUE TO, OR AS A CONSEQUENCE OF: History of previous myocardial infarct | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 24 Jul 1972 to 24 Jul 1972 , that (I) (we) last saw the deceased alive on 24 Jul 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Sidney R. Whorton MD | | | | 23B. DATE SIGNED 24 Jul 72 | | 23C. PHYSICIAN'S NAME (Type) Sidney R. Whorton | |
| 23D. ADDRESS McCully 237 Patapsco Ave 21225 | | | | 23E. DEGREE | | | |
| 24A. BURIAL CREMATION, REMOVAL, (Specify) Burial | | 24B. DATE 7/27/72 | | 24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 24D. LOCATION (City, town, or county) (State) Ritchie Hwy Balto Md. 21225 | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR Sidney R. Whorton | | 25C. FUNERAL DIRECTOR McCully | | ADDRESS 237 Patapsco Ave 21225 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|-------------------------|---|--|--|---|---|--|
| S-536 | | 72 07082 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07082 | |
| BIRTH NO. | | 72 07082 | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) Gertrude I. Snyder | | | | 2. DATE AND HOUR OF DEATH July 25, 1972 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Maryland B. COUNTY 1306 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 909 West 37th Street Baltimore, Md. 21211 | | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 909 West 37th Street 21211 | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct 8, 1892 | 9. AGE (In years last birthday) 79 yrs. | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY - - | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME George Sproul | | | | 14. MOTHER'S MAIDEN NAME Gardner | | | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No - - - | | 16. SOCIAL SECURITY NO. 212-16-0016 | | 17. INFORMANT ADDRESS Edith Hitchcock-918 Stoll St. 21225 | | | |
| 18. CAUSE OF DEATH 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years | |
| | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 19 68 to July 19 72 that (I) (we) last saw the deceased alive on July 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Sheldon Goldgier | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED July 26, 1972 | |
| 23C. PHYSICIAN'S NAME (Type) Sheldon Goldgier | | | | 23D. ADDRESS West 36th Street 21211 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/28/72 | | 24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE RECD BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR Sheldon Goldgier | | 25C. FUNERAL DIRECTOR ADDRESS A. Alan Seitz, Jr. 3818 Roland Ave. | | | |



M-460

72 07083 STATE OF MARYLAND - DEMO
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07083

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) PATRICK MILLER | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 Church Home & Hosp. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 23 1972 10:35a M. | |
| 6. SEX male | | 7. RACE white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 1/8/57 | | 10. AGE (In years last birthday) 15 | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George W. Miller | | 14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2653 | |
| 15. MOTHER'S MAIDEN NAME Patricia Hirsch | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT ADDRESS George W. Miller - 4609 Clareway | |
| 19. CAUSE OF DEATH Drowning DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CAUSE LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) pool | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Patterson Park Swimming Pool | |
| 22D. TIME OF INJURY (APPROX.) 7-23-72 10:15a.m. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? Drowned. | | 23. | |
| I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Marvin S. Platt EXAMINER'S NAME (Type) Marvin S. Platt, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED 7-24 -72 | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | |
| 24B. DATE 7/27/72 | | 24C. NAME of CEMETERY or CREMATORY Most Holy Redeemer | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | | 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | |
| 25B. NAME OF REGISTRAR Sidney W. Houston | | 25C. FUNERAL DIRECTOR ADDRESS Robert C. Altenburg Funeral Home Inc. 6009 Harford Rd. - Balto., Md. 21214 | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07084 |
|--|------------------|--|--|---|
| 72 07084 CERTIFICATE OF DEATH | | | | STATE OF MARYLAND-DEPT |
| BIRTH NO. S-526 | | 1. NAME OF DECEASED (Type or Print) FRANK SENGHER | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 2. DATE AND HOUR OF DEATH 7-23-72 1:40 P.M. | | |
| FULL NAME OF HOSPITAL OR INSTITUTION HARBOR VIEW COWI Home 1213 LYTHER ST S. BALTO MD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 2745 | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN Balto D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| E. STREET AND NUMBER 6425 Harford Rd | | | | |
| S. SEX M | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | B. DATE OF BIRTH 2-17-85 9. AGE (In years last birthday) 87 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Academy | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Czechoslovakia 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME CARL SENGHER | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown | | 16. SOCIAL SECURITY NO. 213-70-8145 | | 17. INFORMANT Joseph Senger ADDRESS 6513 Sutton Ave |
| 18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Dehydration APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 Hours | | |
| | | (B) ASCVD with Chronic Brain Syndrome YEARS | | |
| | | (C) _____ | | |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (X) (this hospital) attended the deceased from February 25 19 72 to July 23 19 72 , that (X) (we) last saw the deceased alive on July 23 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE Peter H. Rheinstein, MD | | | | 23B. DATE SIGNED 24 July 1972 |
| 23C. PHYSICIAN'S NAME (Type) PETER H. RHEINSTEIN, MD | | 23D. ADDRESS HARBOR VIEW NURSING HOME | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/25/72 | | 24C. NAME OF CEMETERY or CREMATORY Most Holy Redeemer Cem. |
| 24D. LOCATION Baltimore | | 24E. LOCATION (City, town, or county) (State) Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR Sidney Johnson | | 25C. FUNERAL DIRECTOR Robert C. Altenburg Funeral Home, Inc. |
| | | | | ADDRESS 6009 Harford Rd. - Balto., Md. 21214 |

FRANK J. SAMPSON

1933-34

RECEIVED BY THE
OFFICE OF THE SECRETARY

1933-34

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FRANK J. SAMPSON

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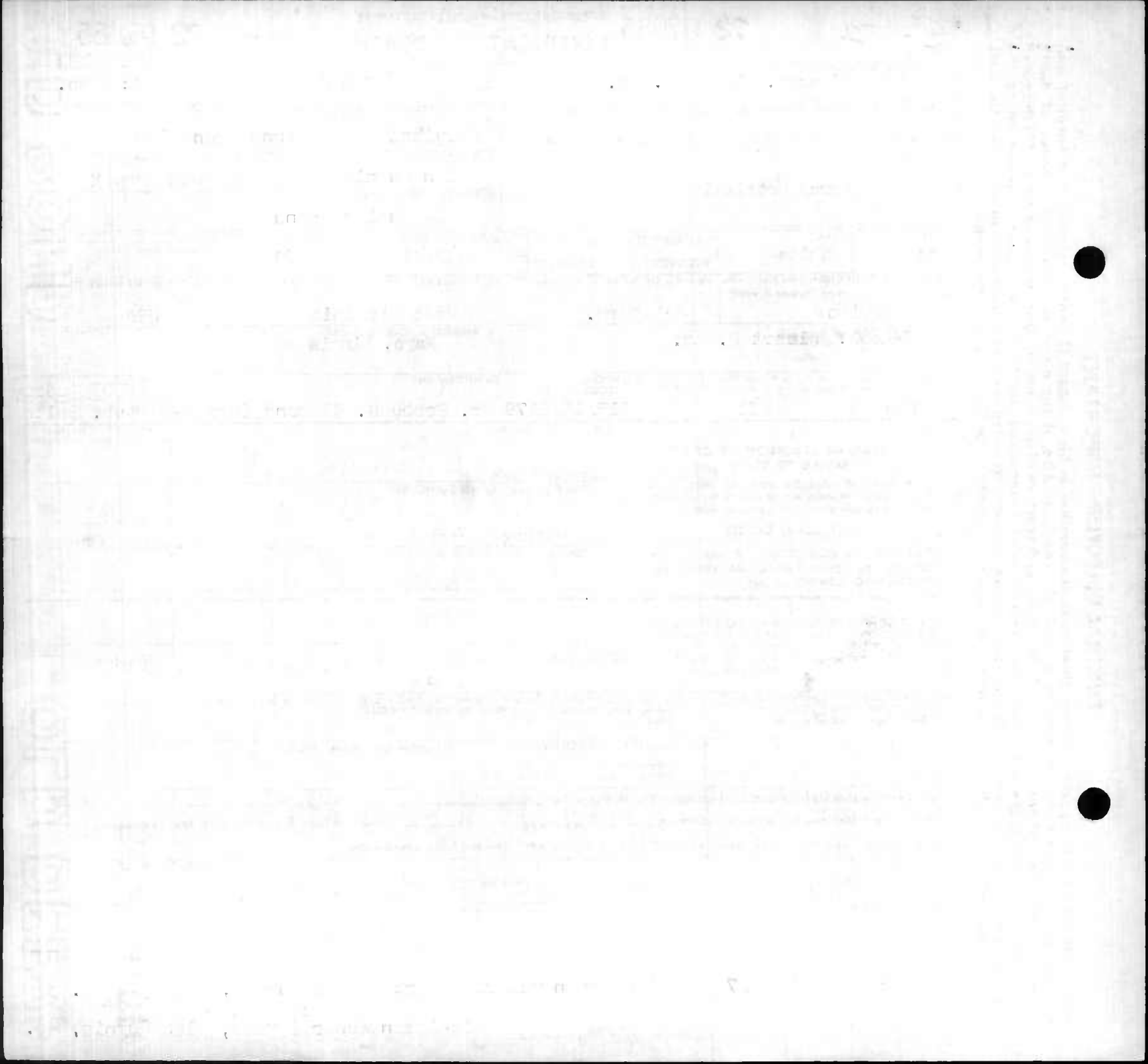
1933-34

1933-34

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

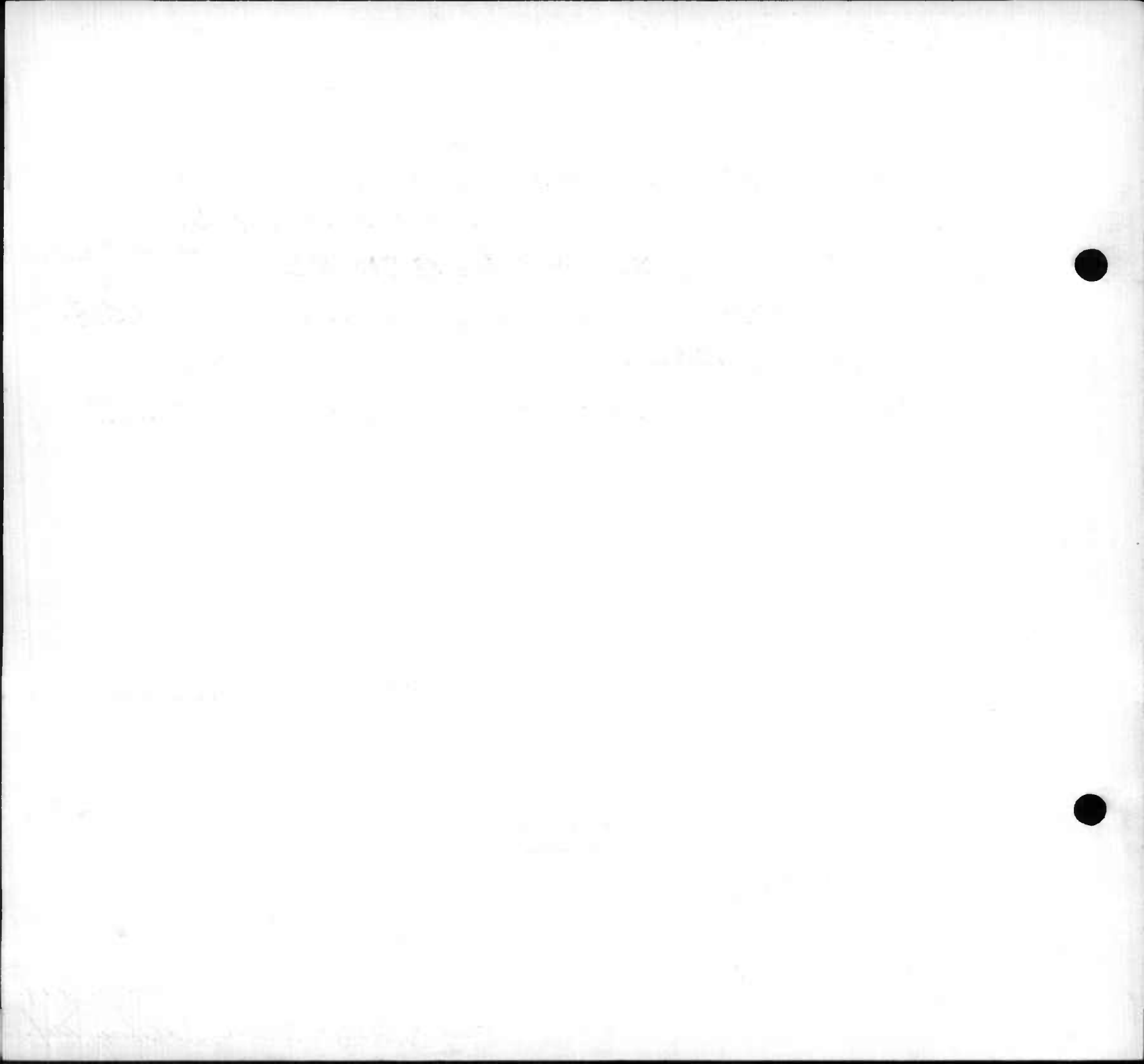
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|------------------|---|---|--|--|----------------------------|--|--|--|
| 72 07085 | | | | | X REG. NO. 72 07085 | | | | |
| STATE OF MARYLAND-DMHM | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) Simmons, Albert D. Jr. | | | | | 2. DATE AND HOUR OF DEATH 7/27/72 6:55 am. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Anne Arundel 5200 C. CITY OR TOWN Glen Burnie D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 204 Phelps Avenue | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8/17/21 | | 9. AGE (in years last birthday) 50 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor | | | 10B. KIND OF BUSINESS OR INDUSTRY AAI Corp. | | 11. BIRTHPLACE (State or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Simmons, Albert D. Sr. | | | | | 14. MOTHER'S MAIDEN NAME Mayo, Minnie | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II | | | 16. SOCIAL SECURITY NO. 215/18/6179 | | 17. INFORMANT Mr. Bobby G. Simmons (brother) Ave. Balto | | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac standstill Acute myocardial infarction (B) DUE TO, OR AS A CONSEQUENCE OF: Intermittent C.V. disease 6 day | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | |
| 20A. AUTOPSY? (Yes or No) No | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 7-21-1972 to 7-27-1972 that (1) (we) last saw the deceased alive on 7-27-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE [Signature] M.D. | | | | | 23B. DATE SIGNED 7-27-72 | | | 23C. PHYSICIAN'S NAME (Type) A.E. WALSH | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | | 24B. DATE 7/31/72 | | 24C. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park | | |
| 24D. LOCATION Glen Burnie, AA Md. | | | | | 24E. NAME OF REGISTRAR [Signature] | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | | | | 25B. NAME OF REGISTRAR [Signature] | | | | |
| 25C. FUNERAL DIRECTOR [Signature] | | | | | 25D. ADDRESS Singleton Funeral Home, Glen Burnie, Md. | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|
| B-652 | | 72 07086 | | BALTIMORE CITY HEALTH DEPARTMENT | | X | | REG. NO. 72 07086 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | STATE OF MARYLAND-DEMB | | | |
| BREWINGTON MORRIS L. | | 7-23-72 | | 9-50 P M. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE | | | | B. COUNTY | |
| Lutheran Hospital of Maryland | | | | Md. | | | | Baltimore | |
| 46 | | | | C. CITY OR TOWN | | | | D. INSIDE CITY LIMITS? | |
| | | | | Baltimore | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER | | | | 1524 FOREST PARK AVE | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (in years last birthday) | |
| Male | | White | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | FEB. 23 1890 | | 82 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Blueberry Ret. | | | | City of Salisbury | | Maryland | | U.S.A | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| Albert L. Brewington | | | | Virginia Williams | | | | | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | | | 214-32-0581 | | Virginia B. Messick | | (Same as 4e.) | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) IMMEDIATE CAUSE | | | | Congestive Heart Failure | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| No | | | | No | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 1 Month (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-17-1972 to 7-23-1972 that (I) (we) last saw the deceased alive on 7-23-1972 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | | | |
| Shad Siddiqi M.D. | | | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| JAWED H. SIDDIQI M.D. | | | | Lutheran Hospital of Maryland | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION | | City, town, or county (State) | |
| Burial | | 7/26/1972 | | Shad Point Cem. | | Shad Point | | Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| JUL 28 1972 | | Audrey Whitton | | Holly Baker - Soundy | | Salisbury Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07087 CERTIFICATE OF DEATH

REG. NO. 72 07087
STATE OF MARYLAND-DEMD

L-163

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARGARET L. LUBERTINE

2. DATE AND HOUR OF DEATH

July 26, 1972

9:14 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)4940 Eastern Avenue Baltimore, Maryland
Baltimore City Hospitals 212244. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1209 South Clinton Street 21224

5. SEX

Female

6. RACE

Caucasian

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

11-27-1893

9. AGE (In years
last birthday)

78

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Charlady

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Rudolph

Hamilton

14. MOTHER'S MAIDEN NAME

Elizabeth

Curry

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) If yes, give war or dates of service

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

4940 Eastern Avenue

BCH: RECORDS Baltimore, Maryland 21224

18. 435.1

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CARDIORESPIRATORY ARREST

(B)

DUE TO, OR AS A CONSEQUENCE OF:

T I Episodes previous

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7-26 DOA 19 72 to 7-26 19 72
that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Peter Joseph Dorsen, M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

7/26/72

23C. PHYSICIAN'S
NAME (Type)

Peter Joseph Dorsen, M.D.

23D. ADDRESS

Baltimore City Hospitals
4940 Eastern Avenue Baltimore, Maryland 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-29-72

24C. NAME of CEMETERY or CREMATORY

Oak Lawn

24D. LOCATION

Balto

(City, town, or county)

(State)

Md

25A. DATE REC'D BY HEALTH DEPT

JUL 28 1972

25B. NAME OF REGISTRAR

Dixie W. Horton

25C. FUNERAL DIRECTOR

Thelma B. Hoffmann 3218 Hudson St

ADDRESS

11-15-1852

Group

the meeting

20

1852

11-15-1852

11-15-1852

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07088

BIRTH NO.

REG. NO.

| | | | |
|--|-------------------------|---|---|
| 1. NAME OF DECEASED (Type or Print) THOMAS YOUNG | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1302 Holbrook Ave. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 23 1972 9:40a M. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 909 | | | |
| 6. SEX male | 7. RACE white | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN Balto. |
| 9. DATE OF BIRTH FEBRUARY 18 1898 | | 10. AGE (In years last birthday) 74 | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 11. BIRTHPLACE (State or foreign country) BALTO., Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | E. STREET AND NUMBER 1302 Holbrook Ave. |
| 13. FATHER'S NAME HENRY S. YOUNG | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | |
| 15. MOTHER'S MAIDEN NAME ANNIE M. FLANAGAN | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | |
| 17. SOCIAL SECURITY NO. NONE | | 18. INFORMANT ADDRESS MR. WILLIAM YOUNG 5604 ANTHONY AVE. | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 412.4 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) no | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Marvin S. Platt EXAMINER'S NAME (Type) Marvin S. Platt, M.D. | | DATE SIGNED 7-24-72 | |
| 24A. BURIAL - CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 7-27-72 | |
| 24C. NAME OF CEMETERY or CREMATORY MOST HOLY REDEEMER | | 24D. LOCATION (City, town, or county) (State) BALTO., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR Sidney W. Boston | |
| 25C. FUNERAL DIRECTOR J. Shalter (Gaskin) | | ADDRESS 5444 BELAIR RD. | |

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1950: 10 10 10 10 10

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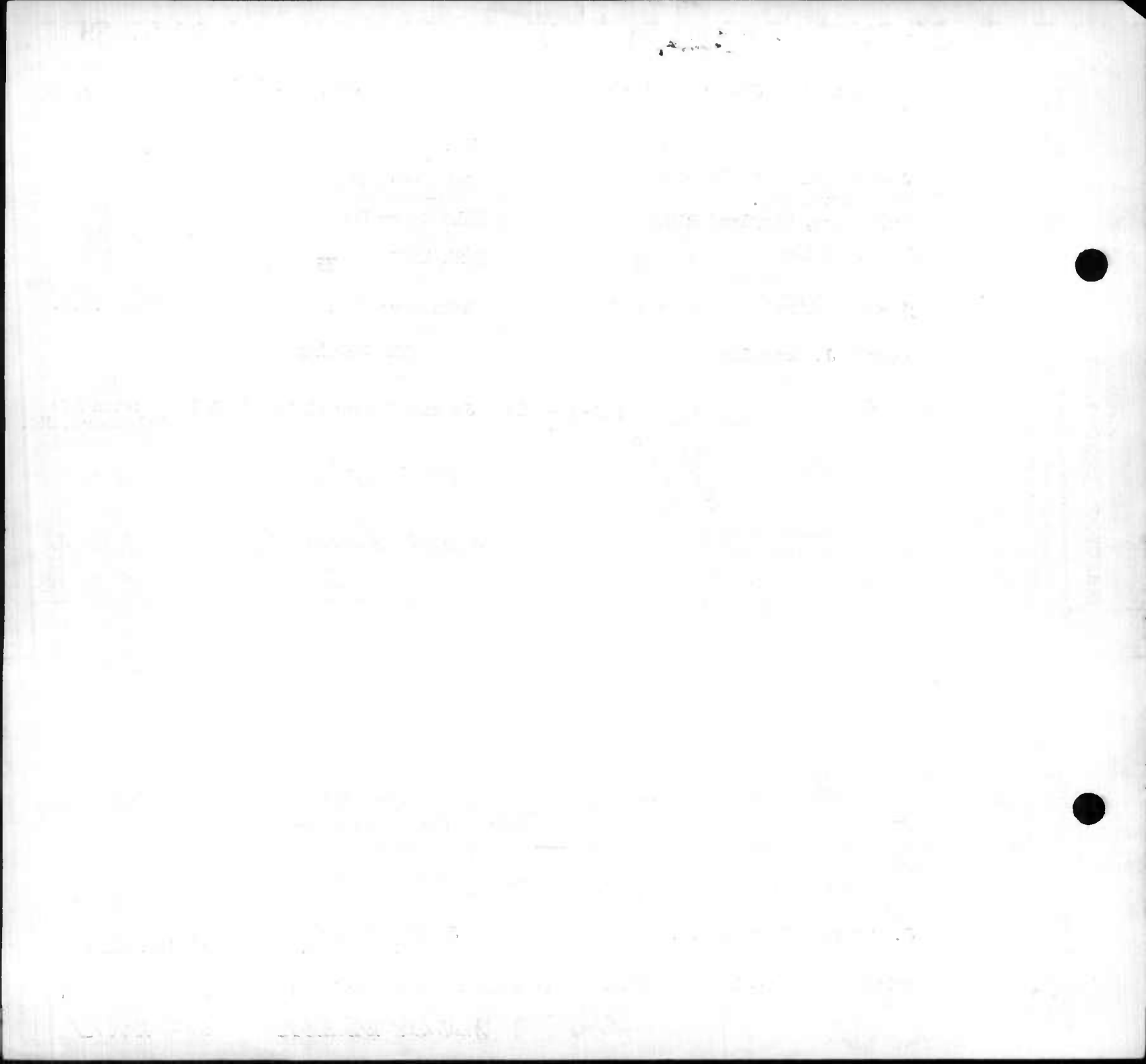
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07089 | |
|---|-------------------------|---|--------------------------------------|---|--|
| G-635 72-07089 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. 6-635 | | STATE OF MARYLAND DEPT. HEALTH | | | |
| 1. NAME OF DECEASED (Type or Print) Katherine Josephine Gordon | | 2. DATE AND HOUR OF DEATH July 24, 1972 | | 7:40A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | A. STATE Md. | |
| FULL NAME OF HOSPITAL OR INSTITUTION Jenkins Memorial Hospital | | C. CITY OR TOWN Baltimore City | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1000 Caton Ave. | | E. STREET AND NUMBER 3810 Ednor Road | | | |
| Baltimore, Maryland 21229 | | | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/21/1897 | 9. AGE (in years last birthday) 74 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Newspaper | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? Yes U.S.A. | | 13. FATHER'S NAME Martin J. Donnelly | | 14. MOTHER'S MAIDEN NAME Ella McNally | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown | | 16. SOCIAL SECURITY NO. 220-24-9013 | | 17. INFORMANT Jenkins Memorial Hospital 1000 Caton Ave Baltimore, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Prostration | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Heat Prostration DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs | |
| ANTECEDENT CAUSE DISEASES OR CONDITIONS, any giving rise to the above cause, and the UNDERLYING CONDITION Heat and humidity | | (B) DUE TO, OR AS A CONSEQUENCE OF: Heat and humidity | | 7 days | |
| | | (C) Parkinson's Disease | | 4 years | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATABLE TO TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Nursing Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3810 Ednor Rd. | |
| 21D. TIME OF INJURY (APPROX.) July 24, 1972 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Heat Prostration during heat wave | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/24/72 to 7/28/72 that (H) (we) last saw the deceased alive on 7/28/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. Raymond Gladue | | 23B. DATE SIGNED 7/29/72 | | 23C. PHYSICIAN'S NAME (Type) J. Raymond Gladue, M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/27/72 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery | |
| 24D. LOCATION Frederick Rd Balto Md. | | 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR Sidney H. Houston | |
| 25C. FUNERAL DIRECTOR McNeill-Woodfield | | 25D. ADDRESS 6500 York Rd | | | |

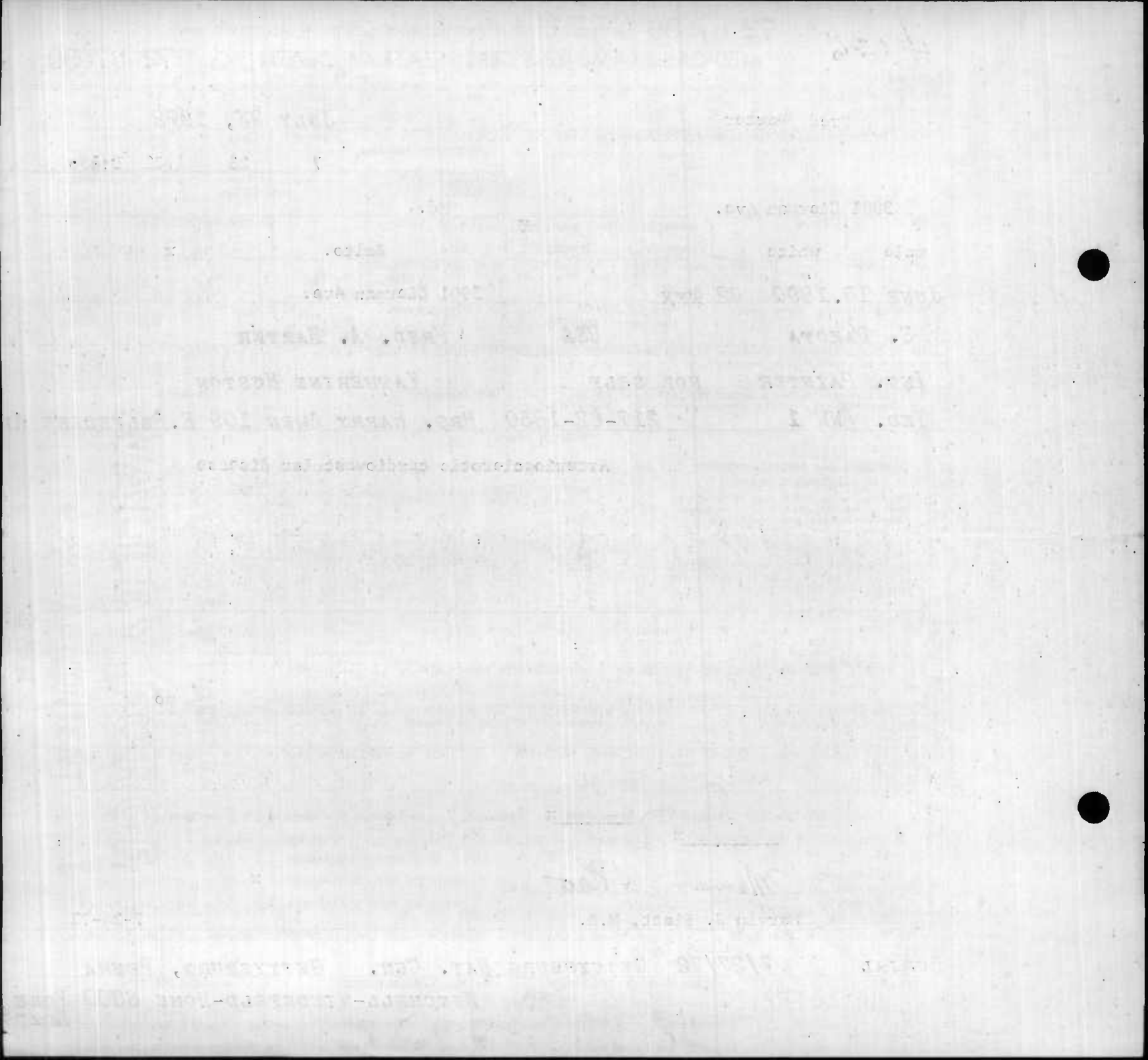


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07090

BIRTH NO.

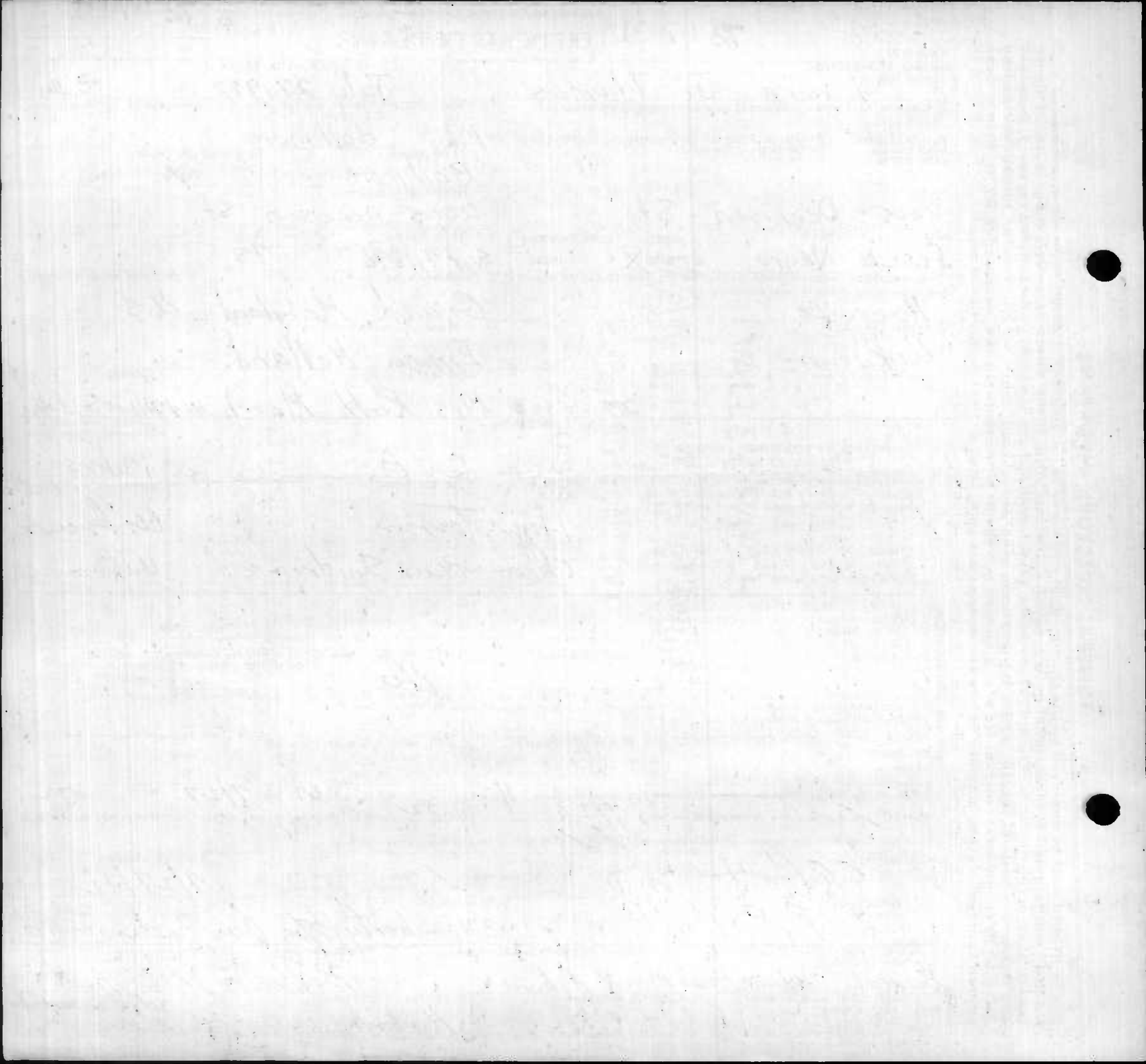
| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Fred Harter | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> JULY 23, 1972 M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3901 Eierman Ave. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 23 1972 3:45p M. | |
| 6. SEX male | | 7. RACE white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH JUNE 18, 1890 | | 10. AGE (In years last birthday) 82 | |
| 11. BIRTHPLACE (State or foreign country) S. DAKOTA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME FRED. A. HARTER | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INT. PAINTER | |
| 15. MOTHER'S MAIDEN NAME KATHERINE HUSTON | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES. WW 1 | |
| 17. SOCIAL SECURITY NO. 217-62-1830 | | 18. INFORMANT MRS. HARRY OWEN 109 E. BELVEDERE A | |
| 19. CAUSE OF DEATH 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) NO | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. DATE SIGNED 7-24-72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 7/27/72 | |
| 24C. NAME OF CEMETERY or CREMATORY GETTYSBURG NAT. CEM. | | 24D. LOCATION. (City, town, or county) (State) GETTYSBURG, PENNA | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR Adrienne W. Horton | |
| 25C. FUNERAL DIRECTOR MITCHELL-WIEDEFELD-HOME | | ADDRESS 6500 YORK ROAD | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|---------|--|---|---|---|--|--|
| T-520 | | 72 07091 | | BALTIMORE CITY HEALTH DEPT. | | 72 07091 | |
| BIRTH NO. | | NAME OF DECEASED | | DATE AND HOUR OF DEATH | | REG. NO. | |
| | | Laura J. Thomas | | July 27, 1972 | | 3:00a.m. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | | A. STATE B. COUNTY | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | Md. Baltimore 1506 | | | |
| 00 2005 Dennison St. | | | | C. CITY OR TOWN D. INSIDE CITY LIMITS? | | | |
| | | | | Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | E. STREET AND NUMBER | | | |
| | | | | 2005 Dennison St | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. UNDER 1 Yr. Months: Days | 11. UNDER 24 Hrs. Hours: Min. | |
| Female | Negro | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | Sept 7, 1896 | 75 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Housewife | | | Granite, Maryland | | U.S. | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | | | |
| Unknown | | | Emma Holland | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | |
| | | | 217-126353 | | Mrs. Ruth Marsh 404 Albee Sq. Bklyn. N.Y. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | |
| | | | CVA | | | | |
| ANTECEDENT CAUSES | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | Hypertension | | | | |
| | | | Chronic Brain Syndrome | | | | |
| | | | Unknown | | | | |
| | | | Unknown | | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/2 1969 to 7/27 1972, that (I) (we) last saw the deceased alive on 7/26 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| E. E. Holt, M.D. | | | | 7/27/72 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| E. E. Holt, M.D. | | | | 3715 Liberty Hts. Ave. Baltimore, Md. 21215 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | Aug 1, 1972 | | Mount Auburn | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JUL 28 1972 | | Sidney H. Whitson | | Herbert P. Nutter F.H. | | 3033 W. North Ave. Baltimore, Md. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|---|--|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | 72 07092 | | 72 07092 | |
| BIRTH NO. | | 72 07092 | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) | | ANNA STEWART | | STATE OF MARYLAND-DHMH | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | 2. DATE AND HOUR OF DEATH | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | md. | | July 24, 1972 | |
| 001906 BARCLAY ST | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER 1906 Barclay St. | | 1204 | | | |
| 5. SEX Female | | 6. RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 2-10-15 | | 9. AGE (In years last birthday) 57 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | |
| 14. MOTHER'S MAIDEN NAME Hattie Harris | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT James C. Stewart | | ADDRESS 1906 Barclay St | | 18. CAUSE OF DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | Chronic Obstructive Lung Disease | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 19 66 to July 19 72 that (I) (we) last saw the deceased alive on June 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE Sheldon Goldstein | |
| 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS 848 W. 36th St. Balt. Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-30-72 | | 24C. NAME OF CEMETERY or CREMATORY DUNN, North Carolina | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT JUL 28 1972 | | 25B. NAME OF REGISTRAR Sheldon Goldstein | |
| 25C. FUNERAL DIRECTOR Wm. C. March | | 25D. ADDRESS 928 E. North Ave | | 25E. ADDRESS Baltimore, Md. | |

11th Barclay St

Home Office

100 E 4th St
New York

Health Commission

Hester St

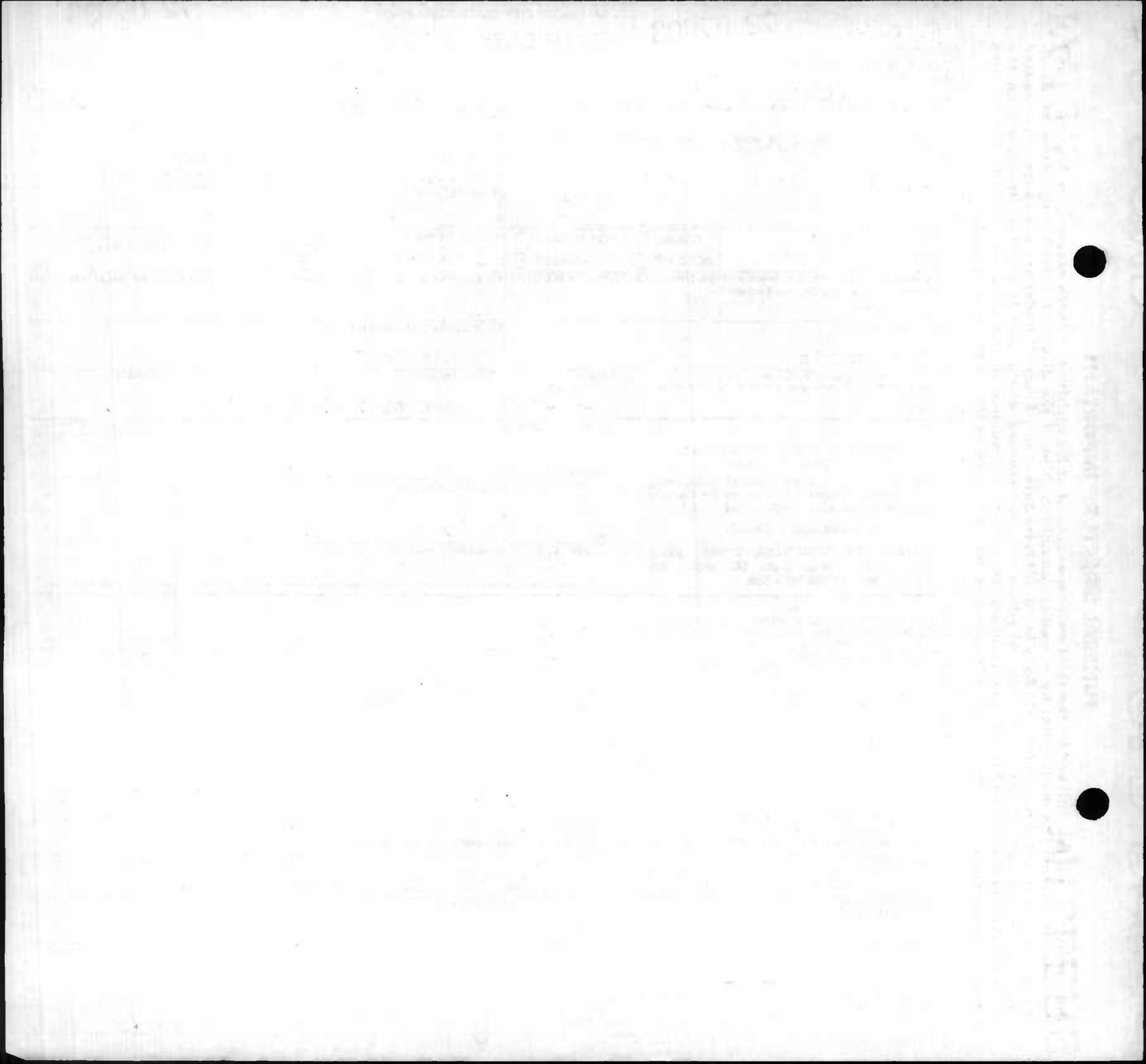
James C. Smith & Co

James C. Smith & Co
100 E 4th St
New York

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

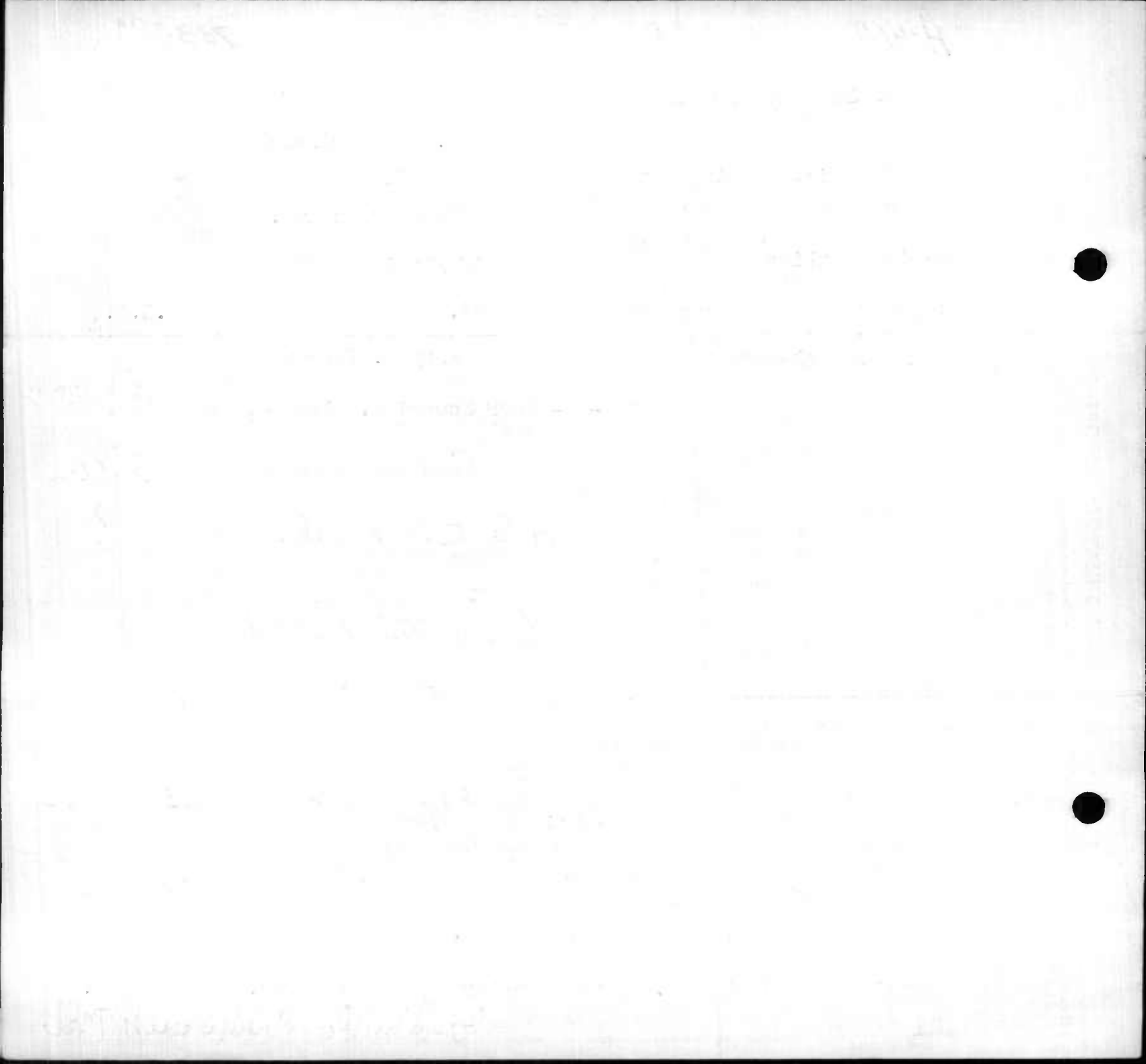
| BIRTH NO. 72 07093 | | | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 72 07093 | | | |
|---|-------------------------|---|-----------------------------------|---|---|---|------------------------------|--|--|------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) Norris, Albert C. | | | | 2. DATE AND HOUR OF DEATH July 25, 1972 2:35 pm | | | | M. M. M. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Baltimore B. COUNTY | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital | | IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 33 | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER 1634 Darley Avenue | | 805 | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 5-6-21 | 9. AGE (In years last birthday) 51 | 10. Under 1 Yr. Months: Days: Hours: Min. | 11. Under 24 Hrs. Hours: Min. | 12. CITIZEN OF WHAT COUNTRY? | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) Alabama | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Plez Morris | | | | 14. MOTHER'S MAIDEN NAME Annie Boyd | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No | | | | 16. SOCIAL SECURITY NO. 408-22-7916 | | 17. INFORMANT Margaret Neal | | ADDRESS 1674 Darley Ave. | | | |
| 18. 1970 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIOVASCULAR COLLAPSE 1 min. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, If any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) 2° Metastatic Lung Carcinoma DUE TO, OR AS A CONSEQUENCE OF: 8 mo. | | | | | | | |
| (C) | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). None | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 1 19 72 to July 25 19 72 that (I) (we) last saw the deceased alive on 2:35 pm July 25 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Mary E. Charlson M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 7/25/72 | | | |
| 23C. PHYSICIAN'S NAME (Type) Mary E. Charlson - M.D. | | | | 23D. ADDRESS 601 N. Broadway Baltimore MD | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-30-72 | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) Lafayette, Alabama | | | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT. JUL 28 1972 | | | | 25B. NAME OF REGISTRAR Lidney Johnston | | | | 25C. FUNERAL DIRECTOR Wm C March ADDRESS 928 E North Ave. | | | |



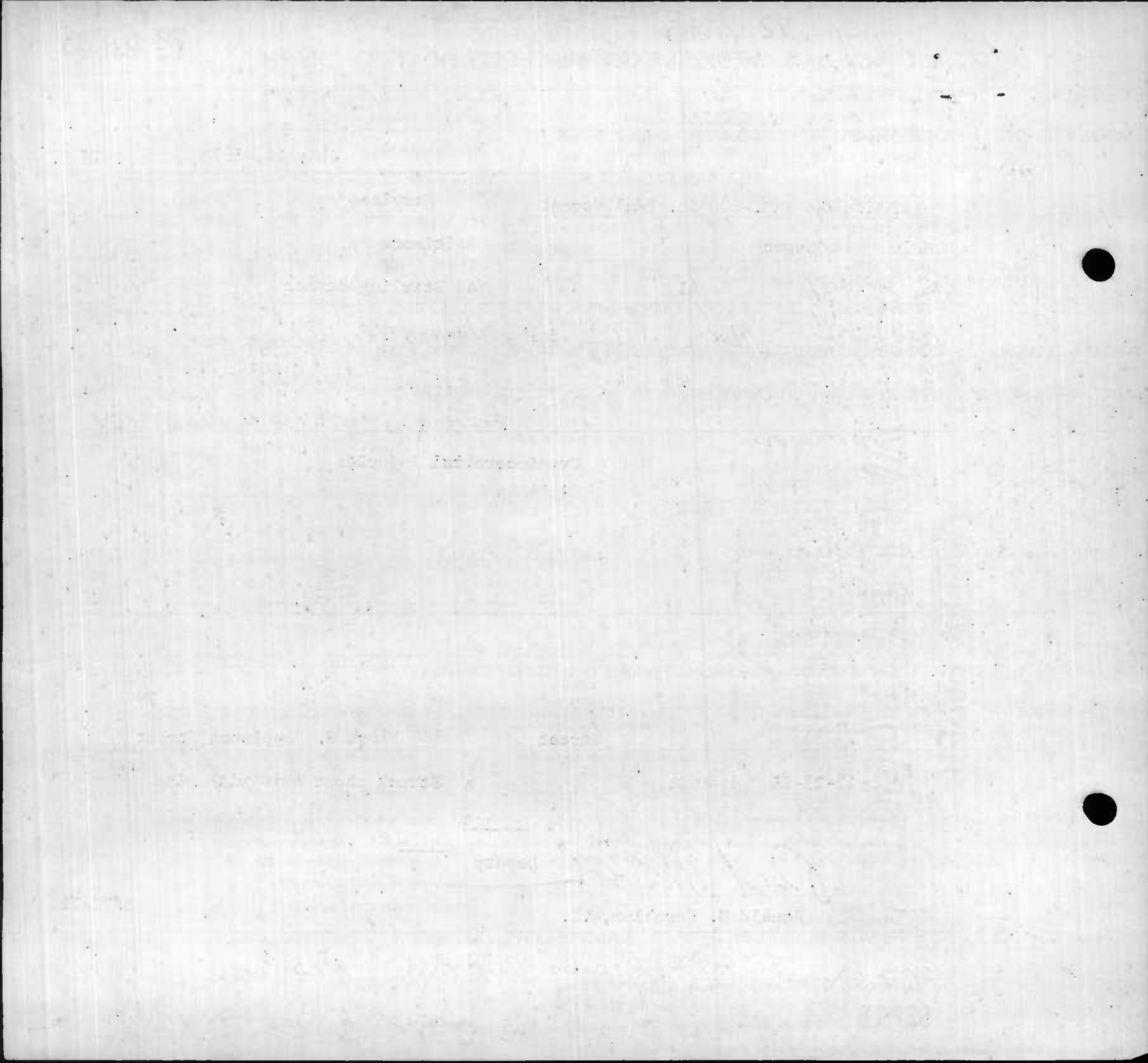
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| A-412 | | 72 07094 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | X REG. NO. 72 07094 STATE OF MARYLAND-DEMH | |
|---|-------------------------|---|--|--|--|---|---|
| 1. NAME OF DECEASED (Type or Print) AL Baugh, Effie | | | | 2. DATE AND HOUR OF DEATH 6 am 7/23/72 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Harbor View Nursing Home 90 H.V. Acc - 1213 Light St. S.W. | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Frederick C. CITY OR TOWN Frederick D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 917 Pontiac Ave. | | | |
| 5. SEX female | 6. RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/7/1893 | 9. AGE (In years last birthday) 79 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY own home | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Eugene A Alexander | | | | 14. MOTHER'S MAIDEN NAME Mary E. Tracey | | | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 214-10-5207B | | 17. INFORMANT Howard M. Albaugh, Frederick, Md | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4/12/41 4250.9 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes Mellitus | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Artery (B) A.S.C. I Disease DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden ? ? | |
| 19A. DATE OF OPERATION 0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 6/11 1970 to 7/23 1972 | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/11 1970 to 7/23 1972 that (I) (we) last saw the deceased alive on 6/27 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | 21F. HOW DID INJURY OCCUR | | | |
| 23A. SIGNATURE Joseph S. Blum | | | | 23B. DATE SIGNED 7/25/72 | | 23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 7/26/72 | | 24C. NAME of CEMETERY or CREMATORY Mt. Olivet Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | | | 25B. NAME OF REGISTRAR Sidney | | 25C. FUNERAL DIRECTOR Goodall, Middle town, Md. | |



| STATE OF MARYLAND-DEMH | | BALTIMORE CITY HEALTH DEPARTMENT | |
|--|--|---|--|
| B-424 | | 72 07095 | |
| BIRTH NO. | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) JAMES BLACKWELL | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MIDTOWN HOME INC.-808 St. Paul Street | | 3. DATE PRONOUNCED DEAD Month Day Year Hour July 24, 1972 2:40 P. M. | |
| 6. SEX Male | | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY | |
| 7. RACE Negro | | C. CITY OR TOWN Baltimore | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH May 8, 1931 | | E. STREET AND NUMBER 645 Stirling Street | |
| 10. AGE (In years last birthday) 41 | | 11. BIRTHPLACE (State or foreign country) Baltimore Md | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A | | 13. FATHER'S NAME James H. Blackwell | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman | | 15. MOTHER'S MAIDEN NAME Thelma Evans | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT Mrs Thelma Evans 4 N. E. 11th St | | ADDRESS | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | 20. DATE OF OPERATION | |
| 21. AUTOPSY? (Yes or No) yes | | 22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street | |
| 23. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 24. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 100 Block N. Poppleton Street | |
| 25. TIME OF INJURY (APPROX.) 12-25-71 1:40 A.m. | | 26. HOW DID INJURY OCCUR? Struck about head with pipe | |
| 27. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 28. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| 29. ACTUAL SIGNATURE: Ronald N. Kornblum, M.D. | | 30. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 31. DATE REC'D BY HEALTH DEPT. SEP 19 1972 | | 32. NAME OF REGISTRAR Sidney Johnson | |
| 33. FUNERAL DIRECTOR Joseph J. Ruggs | | 34. ADDRESS 2222 W. North Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07096 | | 72 07096 | |
|--|--|--|--|---|--|---|--|
| S-320 | | | | 72 07096 | | 72 07096 | |
| BIRTH NO. | | | | 72 07096 | | 72 07096 | |
| 1. NAME OF DECEASED (Type or Print) <u>Stuckey, Lucille</u> | | | | 2. DATE AND HOUR OF DEATH <u>7/21/72</u> <u>12:35 P</u> M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1304</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Provident Hospital INC.</u> | | | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <u>F.</u> 6. RACE <u>N.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH <u>04-21-18</u> | | 9. AGE (In years last birthday) <u>54</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNEMPLOYEED</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>South Carolina</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>United States</u> | | | | 13. FATHER'S NAME <u>James McDaniel</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Julia Belton</u> | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | | |
| 16. SOCIAL SECURITY NO. <u>251-36-2072</u> | | | | 17. INFORMANT <u>Mrs. Robiner Robinson</u> | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Ovarian Ca. & wide spread metastasis.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>0</u> 20A. AUTOPSY? (Yes or No) <u>0</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>0</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) 1(Month) 1(Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <u>N</u> (this hospital) attended the deceased from <u>7/9</u> 19 <u>72</u> to <u>7/21</u> 19 <u>72</u> that <u>N</u> (we) lost saw the deceased alive on <u>7/21</u> 19 <u>72</u> and that in <u>N</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>N</u> (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Rayman S. Alby MD</u> | | | | 23B. DATE SIGNED <u>7/21/72</u> | | 23C. PHYSICIAN'S NAME (Type) <u>RAYMAN S. ALBY MD</u> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 24B. DATE <u>7-25-72</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Church Cem.</u> | |
| 24D. LOCATION <u>Burnsville, S.C.</u> | | | | 24E. FUNERAL DIRECTOR <u>V. Bailey</u> | | 24F. ADDRESS <u>1348 Calhoun Street</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 28 1972</u> | | | | 25B. NAME OF REGISTRAR <u>John P. ...</u> | | 25C. ADDRESS <u>1348 Calhoun Street</u> | |

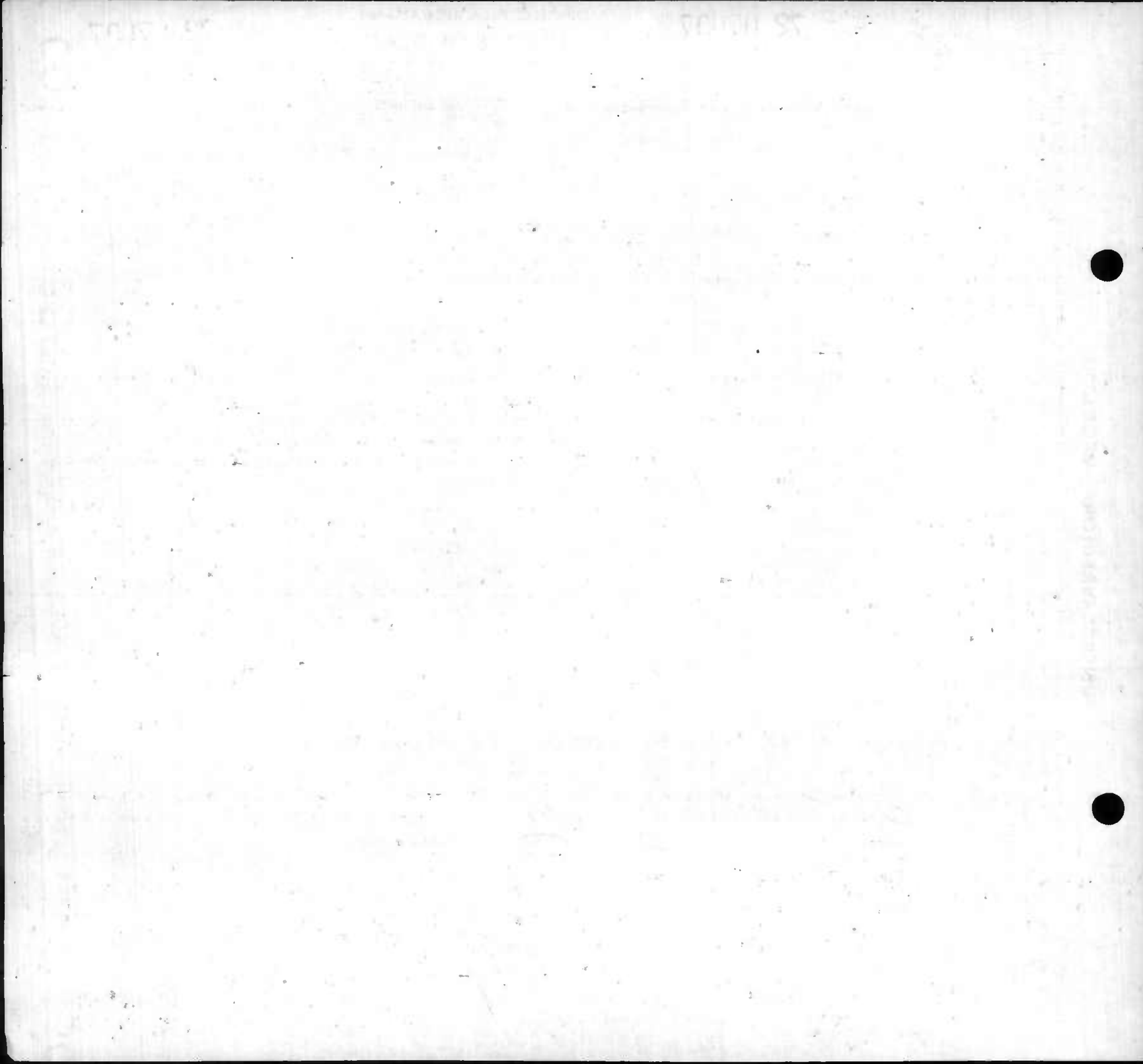
12

81-18

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

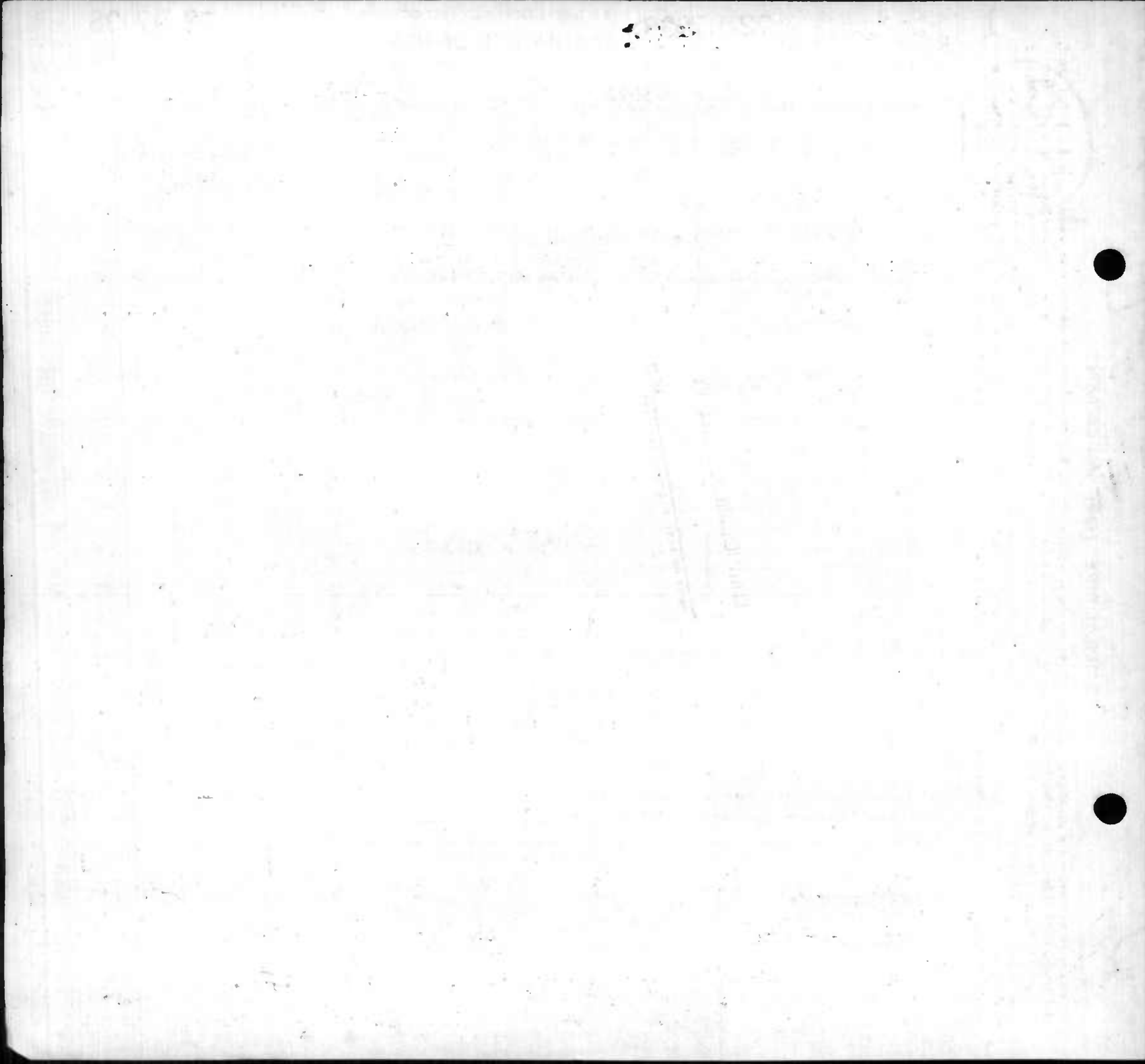
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07097 | | 72 07097 | |
|---|--|--|--|--|--|---|--|
| BIRTH NO. | | | | REG. NO. | | STATE OF MARYLAND | |
| 1. NAME OF DECEASED (Type or Print) Melvin Hudgins | | | | 2. DATE AND HOUR OF DEATH 7-24-72 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY 1506 | | | |
| 5. SEX Male | | | | 6. RACE Negroid | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 2-8-14 | | 9. AGE (In years last birthday) 58 | | 10. UNDER 1 Yr. Months: Days | | 11. UNDER 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Va. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME L. Hudgins | | | |
| 14. MOTHER'S MAIDEN NAME Mary Forrest | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. 217019607 | | | | 17. INFORMANT Ruth Hudgins ADDRESS same | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 412.21 HYPERTENSIVE & ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 YEARS | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from AUGUST 1968 to JULY 17 1972 , that (2) (we) last saw the deceased alive on 7/17 1972 and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above (4) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Jerry Valan, M.D. | | | | 23B. DATE SIGNED 7/25/72 | | 23C. PHYSICIAN'S NAME (Type) JERRY VALAN, M.D. | |
| 23D. ADDRESS UNIV. OF MD. HOSPITAL | | | | 24. LOCATION (City, town, or county) (State) Balto., Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-28-72 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn /cem | | 24D. LOCATION (City, town, or county) (State) Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | | | 25B. NAME OF REGISTRAR Sidney Whitson | | 25C. FUNERAL DIRECTOR V. Bailey ADDRESS Kelson F.H. 1348 Calhoun Street | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| C-320 72 07098 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07098 | |
|---|--|--|--|--|--|---|--|
| BIRTH NO. | | | | REG. NO. | | STATE OF MARYLAND-DEPT | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| Adelle Coates | | | | 7-24-72 | | 2:20 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE | | B. COUNTY | |
| 002012 Etting Street | | | | Maryland | | 1403 | |
| 5. SEX | | | | 6. RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| Female | | | | Negroid | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | | | Md. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | | | Mary Parham same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | Heat prostration | |
| ANTECEDENT CAUSE | | | | (B) High temperature | | 3 days | |
| DISEASES OR CONDITIONS, rise to the above cause | | | | (C) | | | |
| UNDERLYING CONDITION | | | | Arteriosclerotic heart disease | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A) | | | | 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| None | | | | No | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office, bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (APPROX.) July 23, 1972 | | | | While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | Heart Prostration during heat wave | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-21-1972 to 7-24-1972, that (I) (we) last saw the deceased alive on 7-21-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) | |
| C.R. Campbell M.D. | | | | 7-25-72 | | 23D. ADDRESS | |
| C.R. Campbell | | | | 1618 North Ave. Baltimore, Md. | | 24A. BURIAL CREMATION, REMOVAL (Specify) | |
| 24B. DATE | | | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| 7-28-72 | | | | New Gathertgl Cem. | | Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JUL 28 1972 | | | | Sidney H. Heston | | V. Bailey 1348 Calhoun Street | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

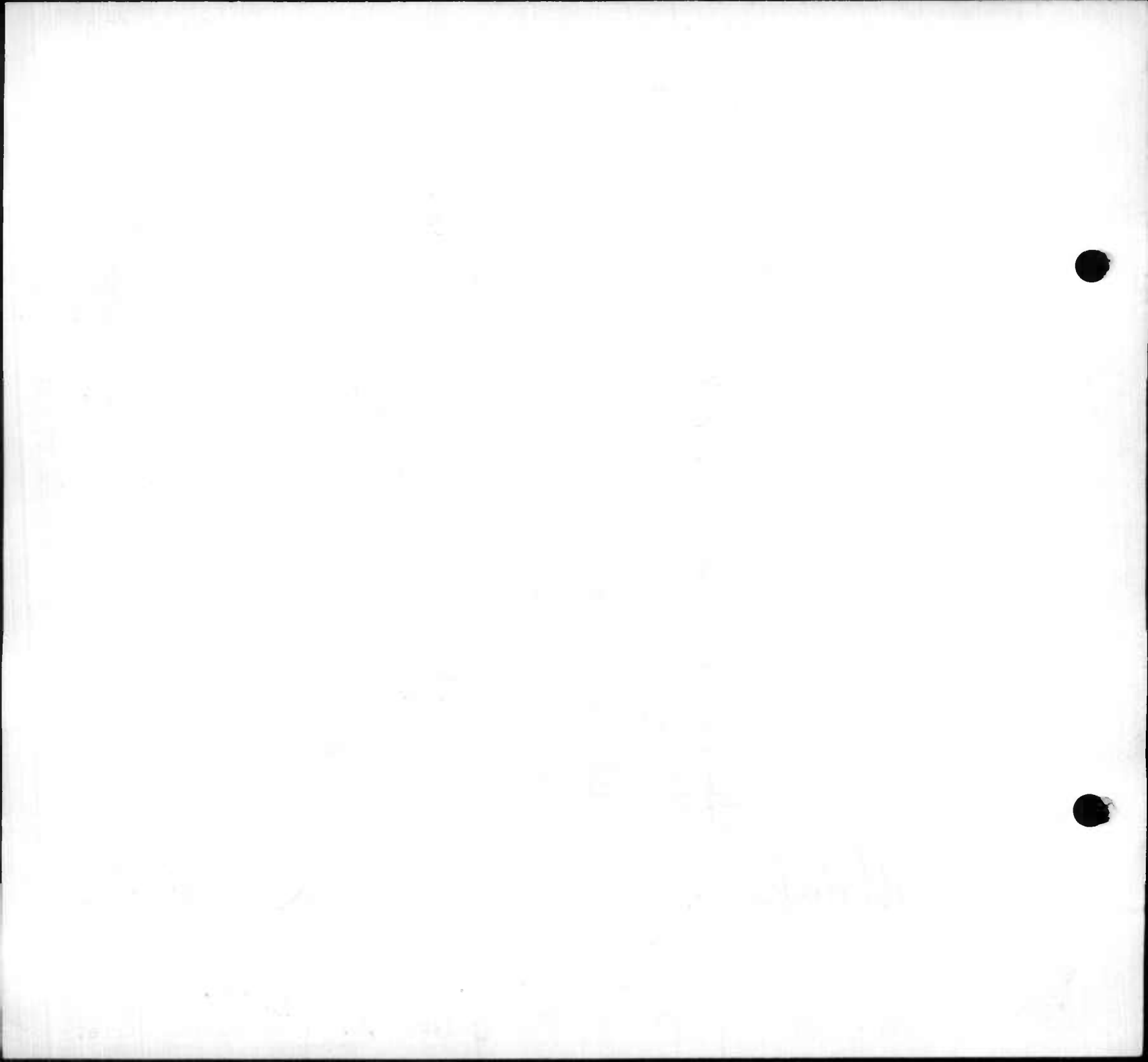
BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Lelia Jackson | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 7 24 72 M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 803 Whitelock St. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 24 72 9:10 p. M. | |
| 6. SEX female | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 1-7-98 | | 10. AGE (In years lost birthday) 74 | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 15. MOTHER'S MAIDEN NAME Carrie Carroll | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT Alverna Cooper-526 E. Wash. Ave. Conn. | | ADDRESS | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME (Month) (Day) (Year) (Hour) (Approx.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 21. AUTOPSY? (Yes or No) yes - head | |
| ACTUAL SIGNATURE Peter Lipkovic, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-29-72 | |
| 24C. NAME of CEMETERY or CREMATORY Western Star Cem. | | 24D. LOCATION (City, town, or county) (State) Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR Lidnykh | |
| 25C. FUNERAL DIRECTOR Nelson F.H. | | ADDRESS 1348 Calhoun Street | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

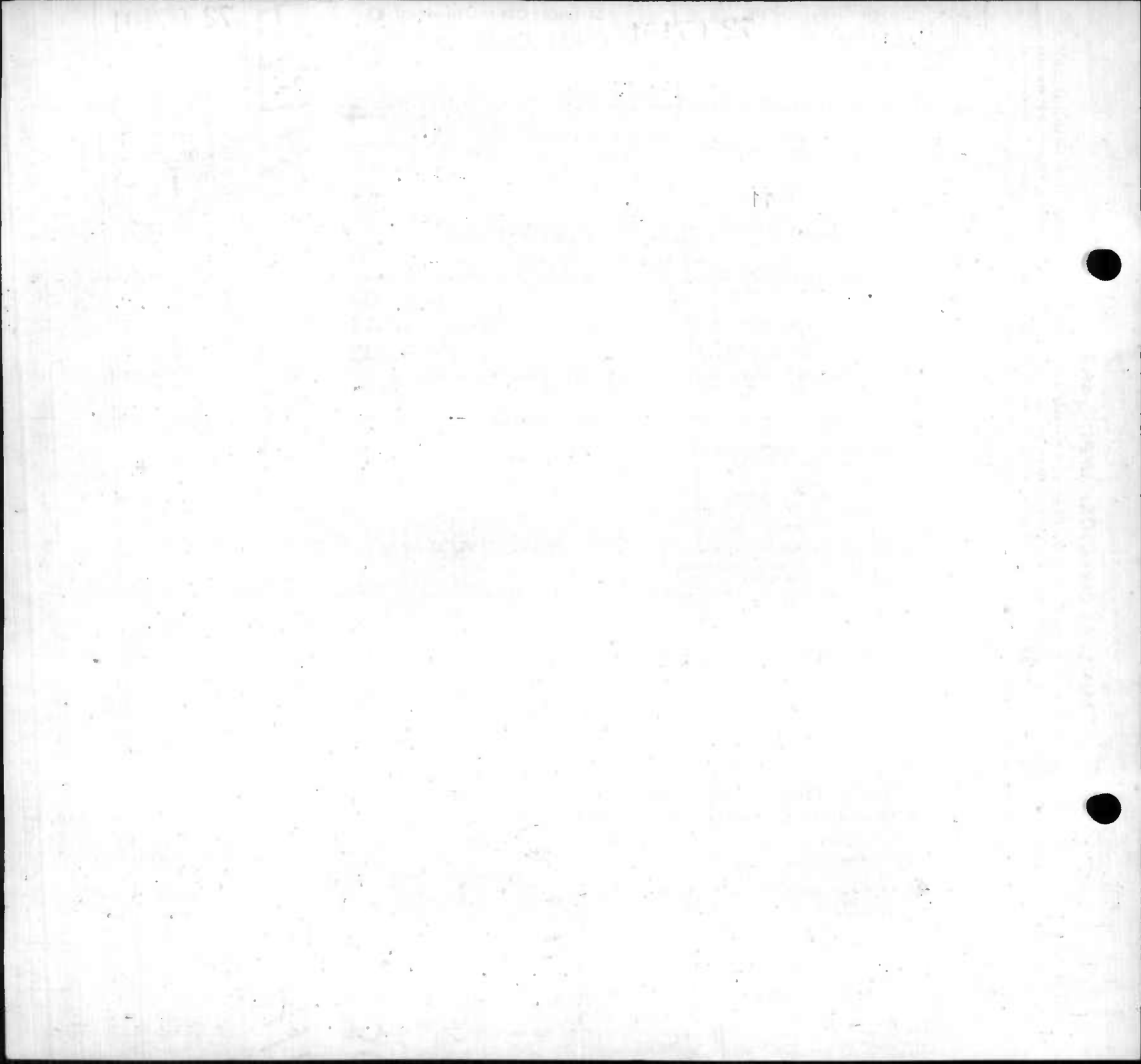
| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 7423 | | 72 07100 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07100 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) | | Fletcher Harvey | | 2. DATE AND HOUR OF DEATH | | 24 Jul 72 10:20 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE Maryland | | B. COUNTY Balto City | |
| 382 University Hospital of Md. | | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER 900 Argyle Ave 14J | | | | | | | |
| 5. SEX Male | | 6. RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH 12/25/31 | |
| 9. AGE (in years last birthday) 40 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME unknown | | | | 14. MOTHER'S MAIDEN NAME Olive Cunningham | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. unknown | | 17. INFORMANT Olive Cunningham Chart | |
| 18. 303.91 CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) IMMEDIATE CAUSE Probable Sepsis | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | | | (B) Alcoholism | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) _____ | | | | _____ | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Approx.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE H. Kasowitz | | | | 23B. DATE SIGNED 7/28/72 | | 23C. PHYSICIAN'S NAME (Type) MARK H. KASOWITZ | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 7-29-72 | | 24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR Redon F.H. | | ADDRESS 1348 Calhoun Street | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07101 | |
|--|--------------|---|---|--|---|
| M-420 | | | | 72 07101 | |
| BIRTH NO. | | | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| Cornelia Mills | | | 7-25-72 | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 00 | | | A. STATE Md. | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 611 Baker St. | | | B. COUNTY 1501 | | |
| | | | C. CITY OR TOWN Balto. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 611 Baker Street | | |
| 5. SEX F | 6. RACE N | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-8-07 | 9. AGE (In years last birthday) 65 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Hewly | | | 14. MOTHER'S MAIDEN NAME Mary | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Weldon Fuller | | |
| | | | ADDRESS 4521 Finney Ave. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 412.2 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH My patient's Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 10 years (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/10 to 7/25 1972, that (I) (we) last saw the deceased alive on 7/15 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Emerson R. Fuller | | | 23B. DATE SIGNED 7/16/72 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-28-72 | | 24C. NAME OF CEMETERY OR CREMATORY Garver Mem. Pk. | |
| | | | | 24D. LOCATION (City, town, or county) (State) Laurel, Md | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR Andrew H. Hopton | | 25C. FUNERAL DIRECTOR V. Bailey Kelson F. G. 1348 Calhoun Street | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Charles Whiting | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 7 24 72 | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3220 Gwynn Falls Pkwy | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 24 72 2:10 p.m. | |
| 6. SEX male | | 7. RACE Negro | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 10-13-90 | | 10. AGE (In years lost birthday) 91 | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 14B. KIND OF BUSINESS OR INDUSTRY B&O RR | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. 705039045 | |
| 15. MOTHER'S MAIDEN NAME Sara Sorrell | | 18. INFORMANT Charles Moore | |
| 19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 21. AUTOPSY? (Yes or No) no | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Peter Lipkovic, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED 7/25/72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-28-72 | |
| 24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem. | | 24D. LOCATION (City, town, or county) (State) Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR Lidney | |
| 25C. FUNERAL DIRECTOR Kelson F.H. | | ADDRESS 1348 Calhoun Street | |

25.10.15

25.10.15

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WILLIAMSON & CO. LTD.

25.10.15

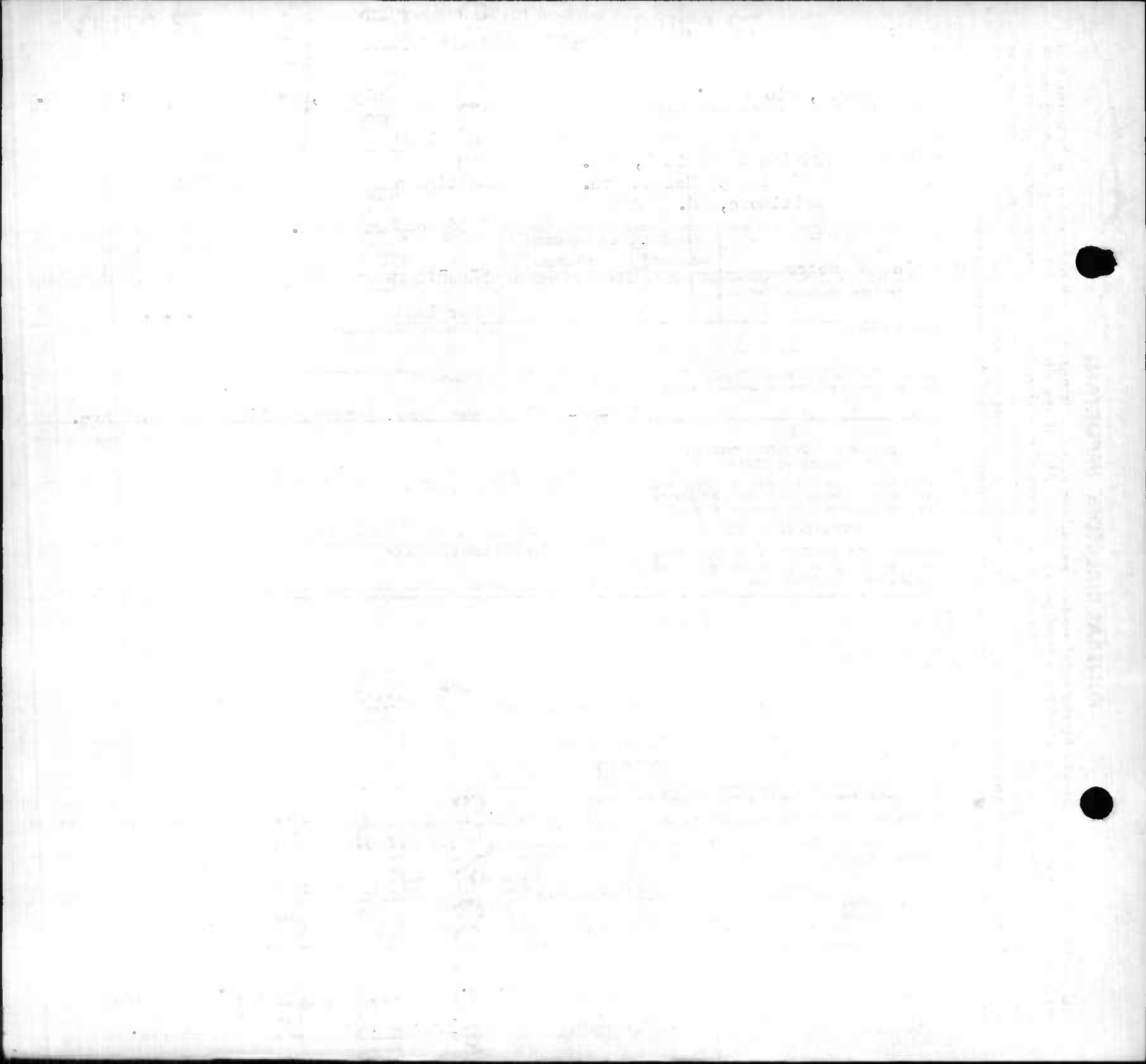
25.10.15

25.10.15

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | 72 07103 | | REG. NO. 72 07103 | |
|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. <u>M-250</u> | | 1. NAME OF DECEASED (Type or Print) <u>Mason, Viola E.</u> | | | |
| 2. DATE AND HOUR OF DEATH <u>July 26, 1972</u> <u>1:30</u> a.m. | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>39</u> <u>Provident Hospital, Inc.</u> <u>2600 Liberty Height Ave.</u> <u>Baltimore, Md. 21215</u> | | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1304</u> | | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 5. SEX <u>Female</u> 6. RACE <u>Negro</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8-11-86</u> 9. AGE (in years last birthday) <u>85</u> | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Emmanuel Mason</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Alice Beads</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | | |
| 16. SOCIAL SECURITY NO. <u>216-42-1622</u> | | 17. INFORMANT <u>John Mason (BROTHER)</u> ADDRESS <u>2835 Woodbrook Ave.</u> | | | |
| 18. <u>151.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Severe Dehydration</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Gastric Malignancy</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>July 25</u> 19 <u>72</u> to <u>July 26</u> 19 <u>72</u> that (I) (we) lost saw the deceased alive on <u>July 26</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>H. BEUGZON, M.D.</u> DEGREE | | 23B. DATE SIGNED <u>7/26/72</u> | | 23C. PHYSICIAN'S NAME (Type) <u>H. BEUGZON, M.D.</u> DEGREE | |
| 23D. ADDRESS <u>PROVIDENT HOSPITAL</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | |
| 24B. DATE <u>7-29-72</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Pk.</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 28 1972</u> | | 25B. NAME OF REGISTRAR <u>Lidney Houston</u> | | 25C. FUNERAL DIRECTOR <u>V. Bailey</u> ADDRESS <u>Kellison F.H. 1348 Calhoun St.</u> | |

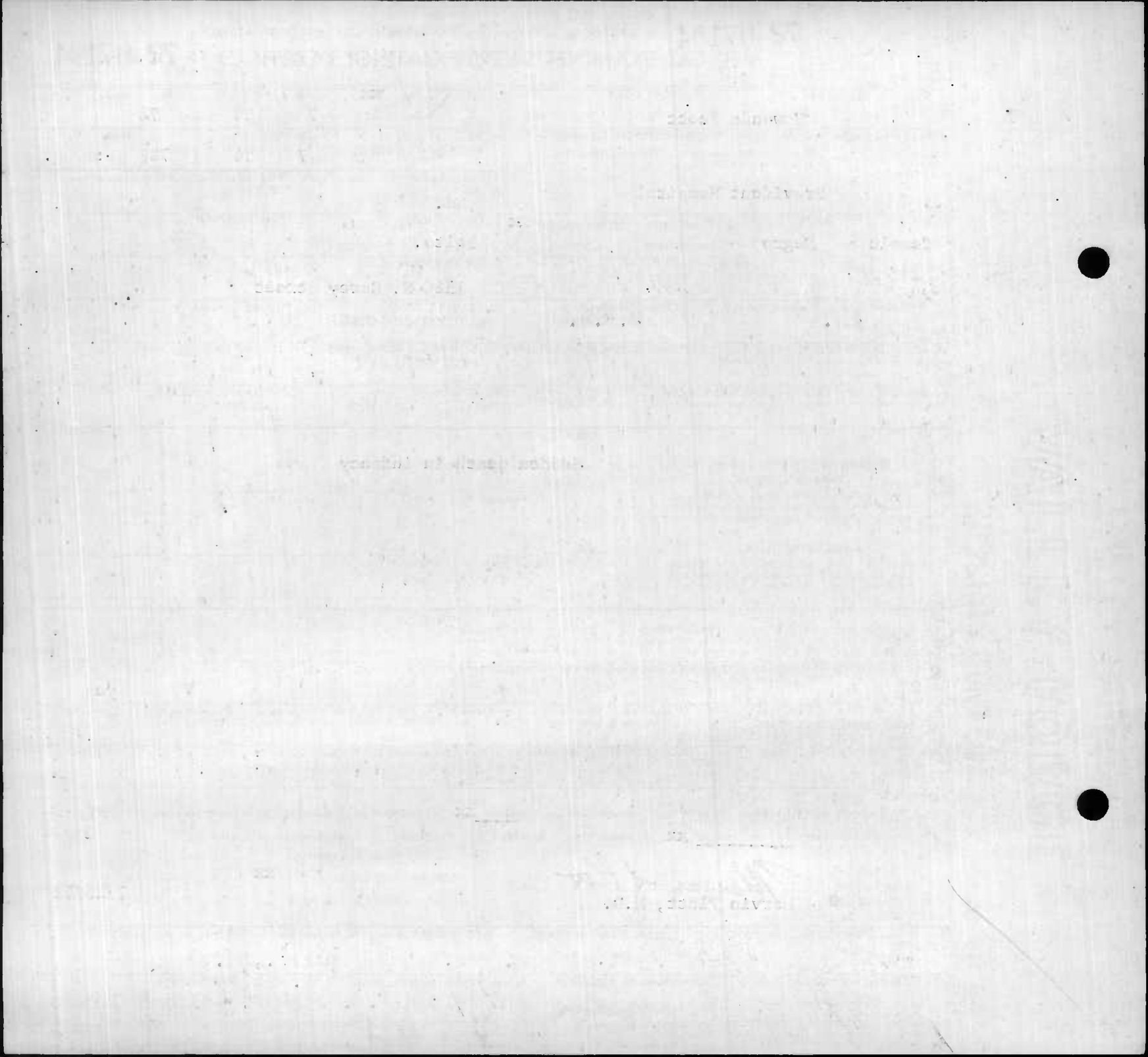


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Towanda Scott | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 7 24 72 M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 24 72 9:00 p. M. | |
| 6. SEX female | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 7. RACE Negro | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 3-17-72 | | 10. AGE (In years last birthday) 4 II Under 1 Yr. II Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 15. MOTHER'S MAIDEN NAME Betty Clark | | 18. INFORMANT Betty Clark ADDRESS same | |
| 19. 795X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | CAUSE OF DEATH Sudden death in infancy (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 21. AUTOPSY? (Yes or No) yes | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt M.D. EXAMINER'S NAME (Type) Marvin Platt, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/25/72 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-28-72 | |
| 24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem. | | 24D. LOCATION (City, town, or county) (State) Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR Lidney | |
| 25C. FUNERAL DIRECTOR V. Bailey | | ADDRESS Nelson F.H. 1348 N. Calhoun Street | |



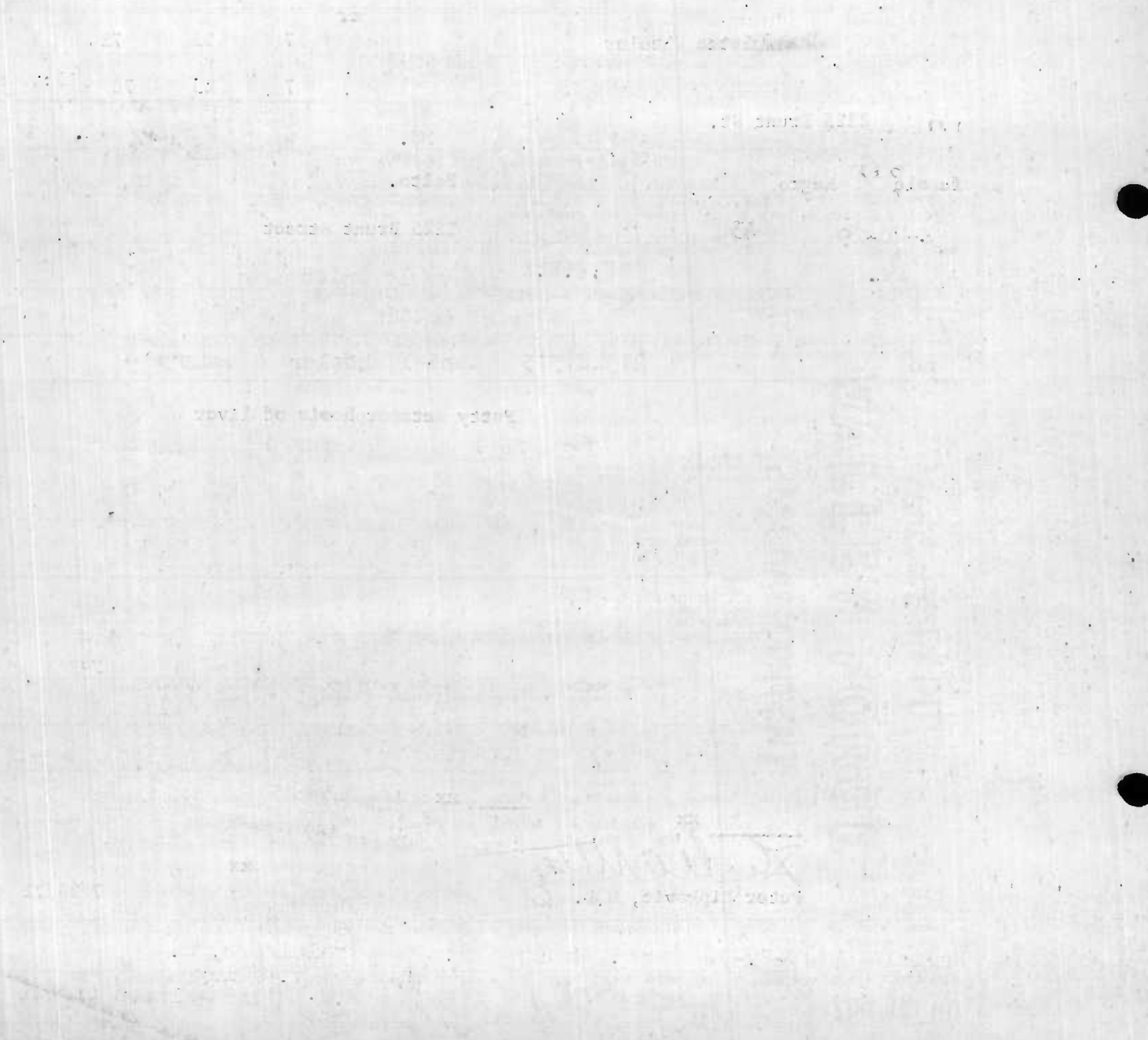
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07105

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Charlotte Wheeler | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 7 Day 25 Year 72 Hour 11:40 a. m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2225 Brunt St. | | 3. DATE PRONOUNCED DEAD Month 7 Day 25 Year 72 Hour 11:40 a. m. | |
| 6. SEX female | | 7. RACE Negro | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE Md. B. COUNTY 1403 | |
| 9. DATE OF BIRTH 2-26-29 | | 10. AGE (In years last birthday) 43 | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 17. SOCIAL SECURITY NO. 215221515 | |
| 18. INFORMANT Daniel Wheeler | | ADDRESS same | |
| 19. 5718 | | CAUSE OF DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Peter Lipkovic, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-29-72 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR Sidney Johnson | |
| 25C. FUNERAL DIRECTOR Kelson F.H. | | ADDRESS 1348 Calhoun Street | |

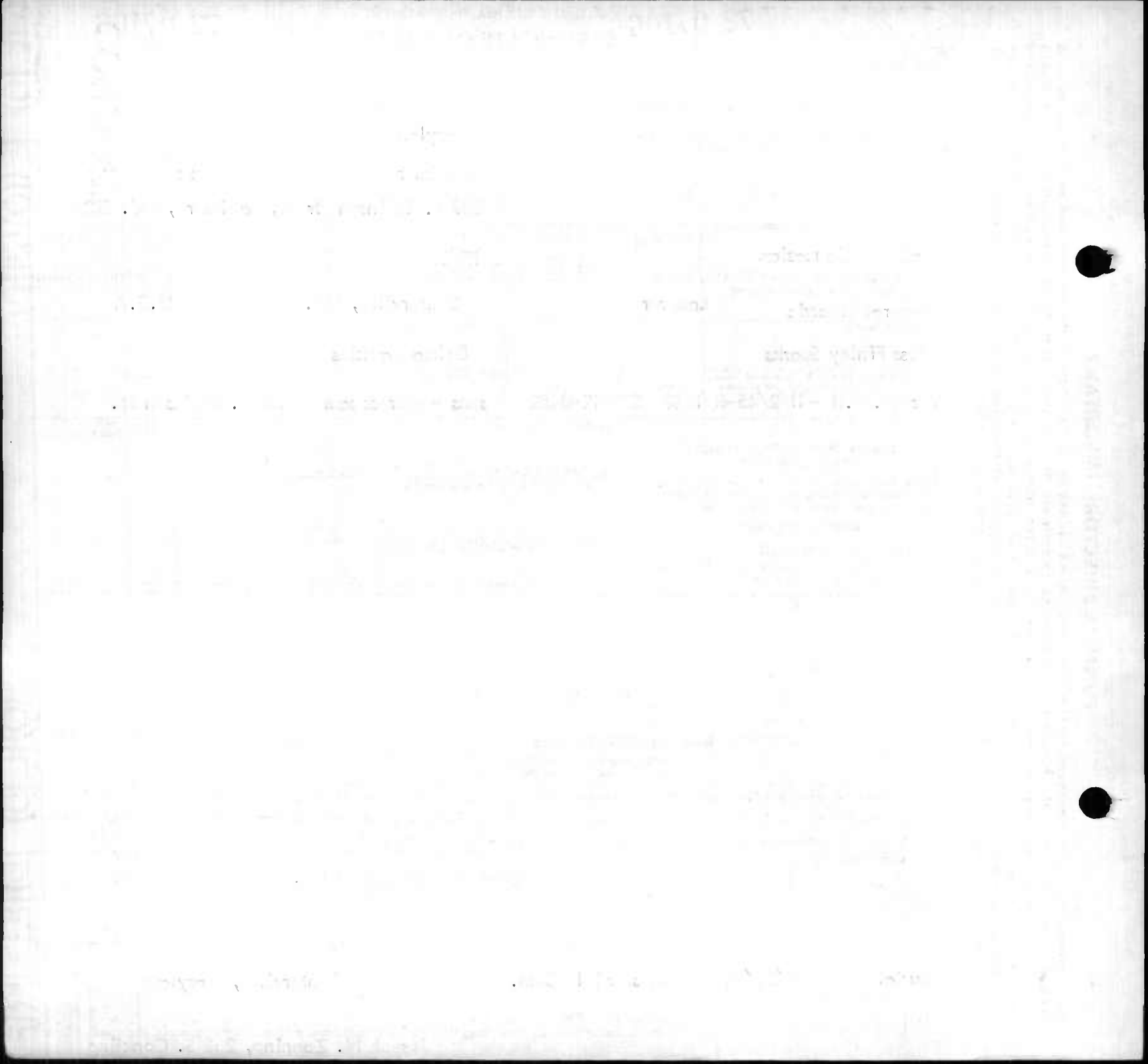
75 100 150 200 250 300 350 400 450 500 550 600 650 700 750 800 850 900 950 1000



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|-----------------------------|---|---|--|--|---|---|
| S-162 | | 72 07106 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07106 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | | | STATE OF MARYLAND-DMH | |
| 1. NAME OF DECEASED (Type or Print) <u>Bonsal Sparks</u> | | | | 2. DATE AND HOUR OF DEATH <u>7-26-72</u> <u>12:40</u> A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>102</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy Hospital Inc.</u> | | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | | | E. STREET AND NUMBER <u>209 S. Robinson Street, Baltimore, Md. 21224</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>Caucasian</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5/17/28</u> | 9. AGE (In years last birthday) <u>44</u> | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Electric</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u> | | 11. BIRTHPLACE (State or foreign country) <u>Centerville, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Ross Finley Sparks</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Delma Dawkins</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <u>Yes - W.W.II - 11/2/45-11/1/48</u> | | | 16. SOCIAL SECURITY NO. <u>220-12-0452</u> | 17. INFORMANT ADDRESS <u>sons - address same - 209 S. Robinson St.</u> | | | |
| 18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardiogenic Shock</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Cardiac arrest - extended anoxia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Myocardial Infarction</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 3/4 hrs</u> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>None</u> | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) <u>this hospital</u> attended the deceased from <u>July 25</u> 19 <u>72</u> to <u>July 26</u> 19 <u>72</u> that (1) <u>lost</u> saw the deceased alive on <u>July 26</u> 19 <u>72</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (1) <u>Yes</u> (2) <u>did</u> (3) <u>did not</u> view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>[Signature]</u> | | | | 23B. DATE SIGNED <u>7/26/72</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>John E. Seibel, MD</u> | | | | 23D. ADDRESS <u>MERCY HOSP.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>7/28/72</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Chesterfield Cem.</u> | | 24D. LOCATION (City, town, or county) (State) <u>Centerville, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 28 1972</u> | | 25B. NAME OF REGISTRAR <u>[Signature]</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Joseph N. Zannino 263 S. Conkling St.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| <p style="font-size: 24pt; margin: 0;">4-653</p> <p style="font-size: 24pt; margin: 0;">72 07107</p> | | <p style="font-size: 24pt; margin: 0;">72 07107</p> | |
| <p style="margin: 0;">BIRTH NO.</p> | | <p style="margin: 0;">REG. NO. 72 07107</p> | |
| <p style="margin: 0;">CERTIFICATE OF DEATH</p> | | <p style="margin: 0;">STATE OF MARYLAND-DBHM</p> | |
| <p>1. NAME OF DECEASED (Type or Print) Marie K. Hormuth</p> | | <p>2. DATE AND HOUR OF DEATH 7/25/72 11:53 P.</p> | |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p>90 General German Aged Peoples Home, 22 S. Athol Avenue</p> | | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE MD B. COUNTY 2864</p> <p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 22 S. Athol Avenue, Baltimore, Md</p> | |
| <p>5. SEX female</p> | <p>6. RACE white</p> | <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p> | <p>8. DATE OF BIRTH 9/3/1892</p> |
| <p>9. AGE (In years last birthday) 79</p> | | <p>10. AGE (In years last birthday) 79</p> | |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> | | <p>10B. KIND OF BUSINESS OR INDUSTRY</p> | |
| <p>11. BIRTHPLACE (State or foreign country) Germany</p> | | <p>12. CITIZEN OF WHAT COUNTRY? USA</p> | |
| <p>13. FATHER'S NAME Late Ludwig Meier</p> | | <p>14. MOTHER'S MAIDEN NAME Late Rosine Muller</p> | |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> | | <p>16. SOCIAL SECURITY NO. 216-01-3580</p> | |
| <p>17. INFORMANT General German Aged Home, 22 S. Athol Avenue</p> | | <p>ADDRESS</p> | |
| <p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE cardio respiratory failure</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) Cerebral vascular hemorrhage</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) Generalized arteriosclerosis</p> | | <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> | |
| <p>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> | | | |
| <p>19A. DATE OF OPERATION</p> | | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> | |
| <p>20A. AUTOPSY? (Yes or No) No</p> | | <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p> | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | |
| <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | | <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p> | |
| <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | | <p>21F. HOW DID INJURY OCCUR?</p> | |
| <p>22. I certify that (I) (this hospital) attended the deceased from June 1971 to 7/25 1972, that (I) (we) last saw the deceased alive on 7/25 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | | | |
| <p>23A. SIGNATURE William J. Bryson</p> | | <p>23B. DATE SIGNED 7/27/72</p> | |
| <p>23C. PHYSICIAN'S NAME (Type) Dr. Wm. J. Bryson</p> | | <p>23D. ADDRESS Westview Mall</p> | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p> | | <p>24B. DATE 7/28/72</p> | |
| <p>24C. NAME OF CEMETERY OR CREMATORY Garden of Faith</p> | | <p>24D. LOCATION (City, town, or county) (State) Baltimore, Maryland</p> | |
| <p>25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972</p> | | <p>25B. NAME OF REGISTRAR Aditya Khosla</p> | |
| <p>25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue</p> | | <p>ADDRESS 2228</p> | |

27 N. L. Wood 21
4/16/1967

1
H-163

72 07108

STATE OF MARYLAND, DEPT. OF HEALTH
BALTIMORE CITY HEALTH DEPARTMENT

72 07108

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Virginia Hubbard | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 7 25 72 M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2423 E. Federal St. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 25 72 8:10 a. M. | |
| 6. SEX female | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH August 18 1914 | | 10. AGE (In years last birthday) 58 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Elyah Thomas | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 15. MOTHER'S MAIDEN NAME Mame Jinter | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 17. SOCIAL SECURITY NO. 217-01-4388 | | 18. INFORMANT Chub Hill Thomas | |
| 19. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/25/72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-29-72 | |
| 24C. NAME OF CEMETERY or CREMATORY Green Gully | | 24D. LOCATION (City, town, or county) (State) Lanham Md | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR Sidney Whitson | |
| 25C. FUNERAL DIRECTOR Charles W. W. W. W. | | ADDRESS 1001 Pennsylvania Ave | |

James H. Watson, Jr.

18

August 18, 1891

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 17th inst. and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

Very respectfully,
James H. Watson, Jr.

Yours truly,
James H. Watson, Jr.

James H. Watson, Jr.

1
H-610

(D U P L I C A T E)

72 07109

STATE OF MARYLAND-DEMH
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07109

BIRTH NO.

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) GEORGE L. HARVEY | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 334 Presstman Street | | 3. DATE PRONOUNCED DEAD Month Day Year July 21, 1972 Hour 8:40 P. | |
| 6. SEX Male | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Maryland B. COUNTY 1403 | |
| 9. DATE OF BIRTH March 10 - 1899 | | 10. AGE (In years last birthday) 73 If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Samuel Harvey | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Diser Harvey | |
| 15. MOTHER'S MAIDEN NAME Maggie M. Roths | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 17. SOCIAL SECURITY NO. 213-07-5345 | | 18. INFORMANT Maggie M. Roths | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) No | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 27, 1972 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-28-72 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem | | 24D. LOCATION (City, town, or county) (State) Balto Md | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR Lidney Johnson | |
| 25C. FUNERAL DIRECTOR Corbison 1000 Maryland Ave | | ADDRESS | |

12/1/87

12/1/87

12/1/87

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[Faint handwritten text]

[Faint handwritten text]

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1
R-360

72 07110

BALTIMORE CITY HEALTH DEPARTMENT

72 07110

MEDICAL EXAMINER'S CERTIFICATE OF DEATH STATE OF MARYLAND - DEPT. REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH RITTER

2. DATE
OF
DEATHKnown ☒
Estimated ☐Month
DayYear
Hour

M.

July 27, 1972

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Hospital (DOA)

3. DATE
PRONOUNCED DEADMonth
DayYear
Hour

M.

July 27, 1972

4:06 A.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Nov. 18, 1942

10. AGE (In years
lost birth day)

29

11. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3322 Fleet Street

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

CHARLES RITTER

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

DOMINO SUGAR
REFINERY

15. MOTHER'S MAIDEN NAME

Sophia MACIJEWSKA

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL
SECURITY NO.

217-388299

18. INFORMANT

Sophia RITTER

ADDRESS

3322 FLEET ST.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Intravenous narcotism
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRI-
BUTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)Charles S. Springate
Charles S. Springate, M.D.CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 27, 1972

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

7-31-72

24C. NAME of CEMETERY or CREMATORY

HOLY ROSARY CEMETERY

24D. LOCATION (City, town, or county)

BALTIMORE

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

JUL 28 1972

25B. NAME OF REGISTRAR

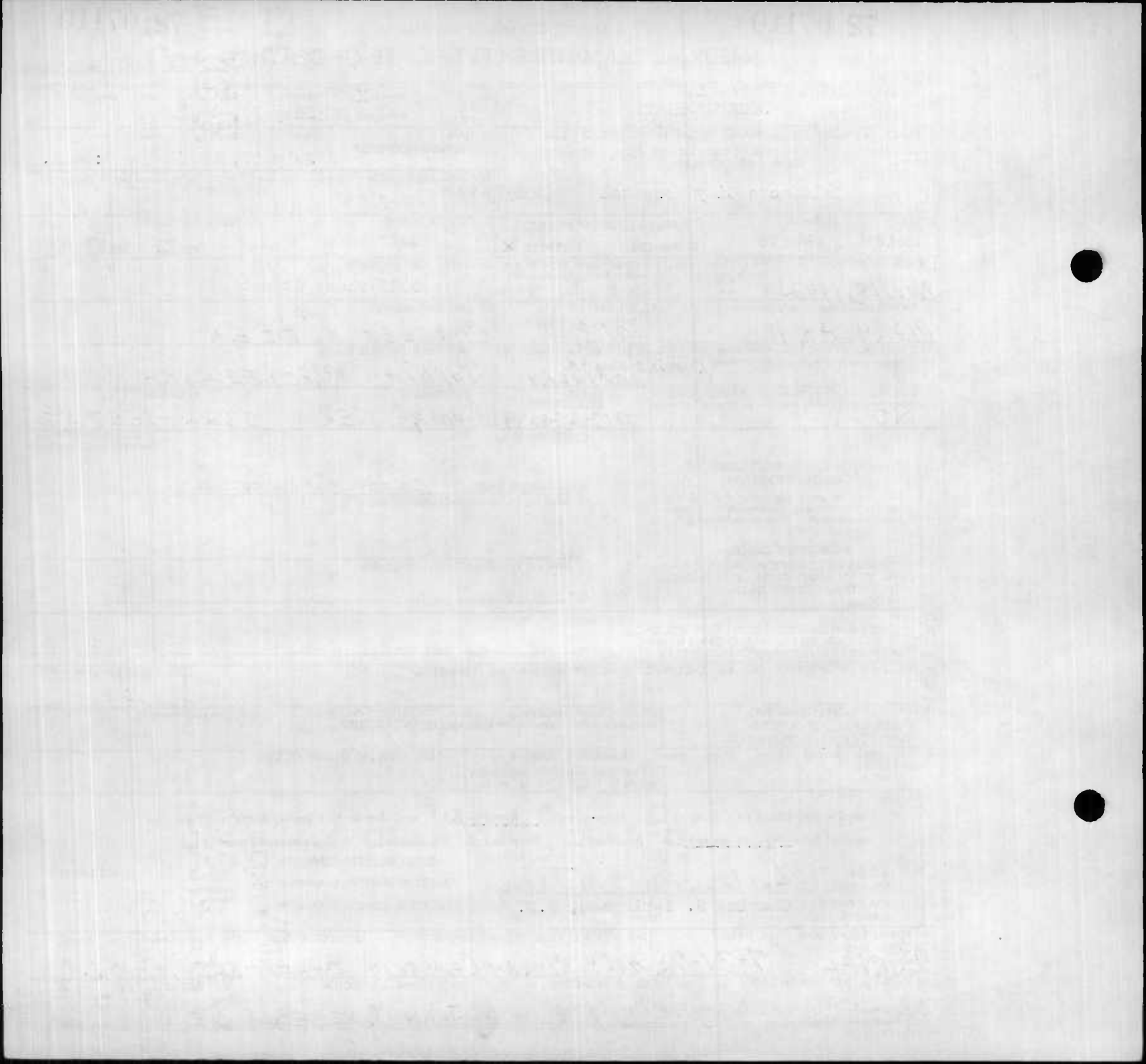
L. J. HORTON

25C. FUNERAL DIRECTOR

John M. WEBER & Sons, Inc.

ADDRESS

401 S. CHESTER
ST.



1

72 07111

BALTIMORE CITY HEALTH DEPARTMENT

72 07111

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND - DEPT. OF HEALTH

0-320

BIRTH NO.

1. NAME OF DECEASED VAMBOLA
(Type or Print) Juri Ots2. DATE OF DEATH Known ☒ Month Day Year Hour
Estimated ☐ 7 24 72 M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF (If not in hospital or institution, give street
HOSPITAL ADDRESS OR LOCATION)
OR INSTITUTION

11 N. Broadway

3. DATE PRONOUNCED DEAD Month Day Year Hour
7 24 72 3:00 p. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Md.

B. COUNTY

604

6. SEX
male7. RACE
White8. MARRIED ☐ NEVER MARRIED ☒
WIDOWED ☐ DIVORCED ☐C. CITY OR TOWN
Balto.D. INSIDE CITY LIMITS?
YES ☒ NO ☐

9. DATE OF BIRTH

JAN 16 1927

10. AGE (In years
lost birthday)

46

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

11 N. Broadway

11. BIRTHPLACE (State or foreign country)

ESTONIAN

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

HAYS ARTHUR OTS

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETIRED SOLDIER

14B. KIND OF BUSINESS OR INDUSTRY

U.S. GOVERNMENT

15. MOTHER'S MAIDEN NAME

ALMA RABISSON

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WORLD WAR II

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

ALMA OTS 11 N BROADWAY 21231

19. 412.4

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

2

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural cause ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S Peter Lipkovic, M.D.
NAME (Type)CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/25/72

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

JULY 28 1972

24C. NAME OF CEMETERY or CREMATORY

MT CARMEL CEMETERY

24D. LOCATION (City, town, or county) (State)

O'DONNELL ST BALTO MD.

25A. DATE REC'D BY HEALTH DEPT.

JUL 28 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

DIPPEL BROS INC 1800 ELOMBARD ST

WIND-A

THE LATER

ESTONIAN

USA

HAVE ANOTHER

REFUSED SERVICE TO GOVERNMENT

ALMA RABISON

WIND-MAN

ALMA RABISON

ALMA RABISON

ALMA RABISON

GRAND

ALMA RABISON

ALMA RABISON

ALMA RABISON

72 07112

BALTIMORE CITY HEALTH DEPARTMENT

72 07112

MEDICAL EXAMINER'S CERTIFICATE OF DEATH STATE OF MARYLAND-DHMH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

DOROTHY BETZ DR. JONES

2. DATE
OF DEATHKnown ☒
Estimated ☐Month
JULYDay
26,Year
1972Hour
M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Hospital (DOA)

3. DATE
PRONOUNCED DEADMonth
JulyDay
26,Year
1972Hour
9:05 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

202

6. SEX

Female

7. RACE

White

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

AUG 18 1920

10. AGE (In years
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

213 S. Durham Street

11. BIRTHPLACE (State or foreign country)

DETROIT MICH

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOE KIRBY

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSE WIFE

14B. KIND OF BUSINESS OR INDUSTRY

—

15. MOTHER'S MAIDEN NAME

JOSE SMITH

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL
SECURITY NO.

218-28-2028

18. INFORMANT

ADDRESS

HARRY BETZ 213 S DURHAM ST

19.

485-X1

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Bronchopneumonia

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Marvin S. Platt, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 27, 1972

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

JULY 28 1972

24C. NAME OF CEMETERY or CREMATORY

MT CARMEL CEMETERY

24D. LOCATION (City, town, or county) (State)

O'DONNELL ST BALTO MD

25A. DATE REC'D BY HEALTH DEPT.

JUL 28 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

DIPPEL BROS INC 1800 E LOMBARO ST

APR 18 1960

DAVID MICH

HOUSE WIFE

IN

USA

-

THE MARY

JOHN SMITH

ST-2-2-1 MARY BETH AND 2 OR 3 MARY

BURIAL THE STATE OF CALIFORNIA

DIFFER FROM THE ABOVE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. <u>72 07113</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. <u>72 07113</u> | |
|--|---------------------|---|------------------------------------|--|--|
| STATE OF MARYLAND - DIME | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>ANNIE BROWN</u> | | 2. DATE AND HOUR OF DEATH <u>7/25/72</u> <u>15:20</u> P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>33</u> <u>JOHNS HOPKINS HOSPITAL</u> <u>BALTIMORE, MARYLAND 21205</u> | | A. STATE <u>MARYLAND</u> | | B. COUNTY <u>1001</u> | |
| | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <u>709 E. CHASE ST.</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>B</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/20/12</u> | 9. AGE (In years last birthday) <u>60</u> | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>-</u> | | 11. BIRTHPLACE (State or foreign country) <u>S. Carolina</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Sam Sympton</u> | | 14. MOTHER'S MAIDEN NAME <u>EMMA Wylie</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Shallin Brown 709 E. Chase St.</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>4/12/21</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH <u>Cardiomyopathy - arrhythmia</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>HASCUD</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u> <u>unknown</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u> | | 21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>INJURY OCCUR?</u> | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (mostly medical examined) | | 21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21C. HOW DID INJURY OCCUR? | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7/24</u> 19 <u>72</u> to <u>7/25</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>7/25</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>John B. Welch M.D., Ph.D.</u> | | 23B. DATE SIGNED <u>7/25/72</u> | | 23C. PHYSICIAN'S NAME (Type) <u>JOHN B. WELCH M.D., Ph.D.</u> | |
| 23D. ADDRESS <u>JOHNS HOPKINS</u> | | 23E. ADDRESS <u>BALTIMORE MD</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>7-29-72</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Reisterstown Park</u> | |
| 24D. LOCATION <u>2nd</u> | | 24E. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 28 1972</u> | | 25B. NAME OF REGISTRAR <u>Dorothy M. Brown</u> | | 25C. FUNERAL DIRECTOR <u>Edw. J. Brown</u> | |
| 25D. ADDRESS <u>1129 N. G. St.</u> | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

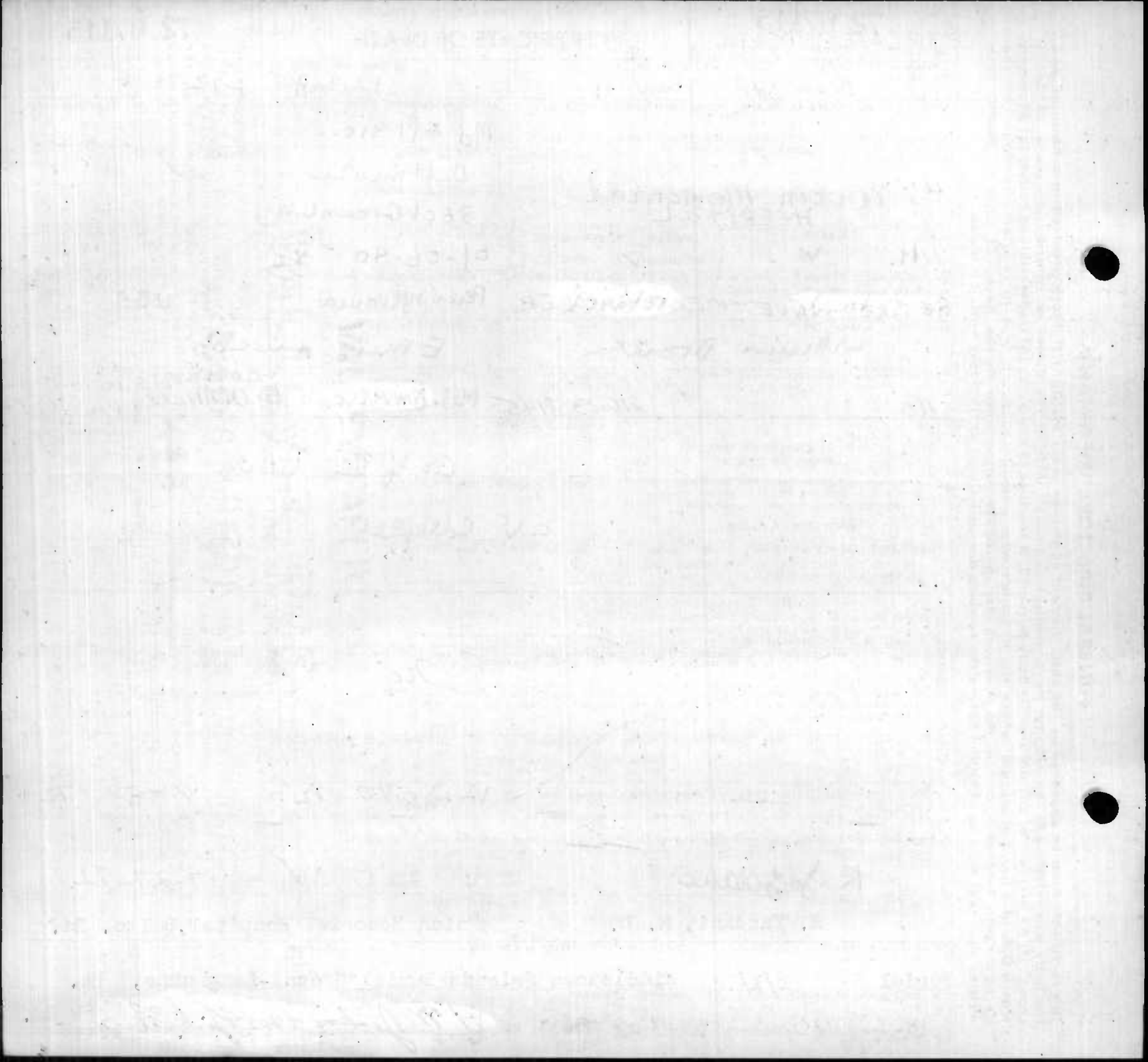
| Baltimore City Health Department | | | | REG. NO. 72 07114 | |
|--|------------------|---|--|--|--|
| 72 07114 CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. <u>72 07114</u> | | 1. NAME OF DECEASED (Type or Print) <u>STATE OF MARYLAND-DECEASED DOELLER, BERTHA S. (Mrs)</u> | | | |
| 2. DATE AND HOUR OF DEATH <u>7-26-72 9 pm</u> | | M. <u>12 01</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>M.D.</u> B. COUNTY <u>12 01</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u> <u>44</u> | | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER <u>3700 N CHARLES ST.</u> | | | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-8-89</u> | 9. AGE (In years last birthday) <u>83</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | |
| 13. FATHER'S NAME <u>ALBERT STRUEN</u> | | | 14. MOTHER'S MAIDEN NAME <u>AMELIA GEBB</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>216-46-4646</u> | | 17. INFORMANT (SON) <u>JOHN L. DOELLER</u> | |
| 18. <u>412.31</u> | | CAUSE OF DEATH | | ADDRESS <u>427 ROSEBANK AVE</u> <u>21212</u> | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE <u>Cardiovascular collapse</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ASHD</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <u>X</u> (this hospital) attended the deceased from <u>7/24</u> 19 <u>72</u> to <u>7/26</u> 19 <u>72</u> , that <u>X</u> (we) last saw the deceased alive on <u>7/26</u> 19 <u>72</u> and that in <u>our</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>X</u> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>M. Yazdani</u> | | | | 23B. DATE SIGNED <u>7-27-72</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>MAHIN YAZDANI, MD</u> | | | | 23D. ADDRESS <u>Union Memorial Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Entombment</u> | | 24B. DATE <u>7/28/72</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Greenmount Mausoleum</u> | |
| 24D. LOCATION (City, town, or county) <u>Baltimore</u> | | (State) <u>Md.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 28 1972</u> | | 25B. NAME OF REGISTRAR <u>Dorothy Whitton</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212</u> | |

MANHATTAN YACHT CLUB

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 72 07115 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07115 | |
|---|---------------------|---|--|--|--|--|--|
| BIRTH NO. STATE OF MARYLAND-DEATH | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Brown, H.A. Stanley</u> | | | | 2. DATE AND HOUR OF DEATH <u>12.30 PM 7-27-72</u> M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>44 Union Memorial Hospital</u> | | | | A. STATE <u>Md</u> B. COUNTY <u>AP 310</u> | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER <u>3601 Greenway</u> | | | | | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>01-06-90</u> | 9. AGE (In years last birthday) <u>82</u> | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED-INVESTMENT-BANKER</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u> | | 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>William Brown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Emily A Webb.</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. <u>216-03-8145</u> | | 17. INFORMANT <u>Mrs. CHARLENE B. DiMICCO</u> ADDRESS <u>CORNWELL HEIGHTS, PA. 19020</u> | |
| 18. <u>162.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>Ca of the lungs</u> <u>C.V. Collapse</u> | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF (B) <u>C.V. Collapse</u> DUE TO, OR AS A CONSEQUENCE OF (C) _____ | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At <input type="checkbox"/> Work Not White At <input type="checkbox"/> Work | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12.30 PM 7-27 1972</u> to <u>7-27 1972</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>K. Yazdani</u> | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>7-27-72</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>K. Yazdani, M. D.</u> | | | | 23D. ADDRESS <u>Union Memorial Hospital, Balto. Md.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>8/1/72</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Middletown Friends Burial Ground-Langhorne, Pa.</u> | | 24D. LOCATION (City, town, or county) (State) <u>Balto., Md. 21212</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 28 1972</u> | | 25B. NAME OF REGISTRAR <u>Lidnysh...</u> | | 25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|----------------------|---|-----------------------------|--|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | 72 07116 | | REG. NO. 72 07116 | |
| BIRTH NO. S-325 | | 72 07116 | | STATE OF MARYLAND-DEMD | |
| 1. NAME OF DECEASED (Type or Print) | | Patrick William Stakem | | 2. DATE AND HOUR OF DEATH July, 26, 1972 8:45 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 2X US Public Health Service Hospital, 3100 Wyman Parkway | | A. STATE Md. Allegany | | B. COUNTY 5100 | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN Midland | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER Paradise St. | | | |
| 5. SEX M | 6. RACE Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/18/25 | 9. AGE (In years lost birthday) 46 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Plant Protection | | Hercules Powder Co. | | Md. USA | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| Patrick Wm. Stakem, Sr. | | Thelma Clise | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| Yes USAF 1943-1945 | | 216-22-5227 | | Records - US PHS Hospital, Balto, Md. | |
| 18. 205701 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | (A) IMMEDIATE CAUSE Gastrointestinal hemorrhage & bronchopneumonia | | Days | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: Acute myelomonocytic leukemia | | 1 month | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | yes | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | July 11 | | 72 July 26 72 | |
| 22. I certify that (I) (this hospital) attended the deceased from July 26 1972 to July 26 1972, that (I) (we) last saw the deceased alive on July 26 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Arthur B. Abt, M.D. | | 23B. DATE SIGNED 7/26/72 | | | |
| 23C. PHYSICIAN'S NAME (Type) Arthur B. Abt - Surgeon | | 23D. ADDRESS US PHS HOSPITAL, Balto, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/29/72 | | 24C. NAME OF CEMETERY or CREMATORY St. Joseph Cemetery | |
| | | | | 24D. LOCATION Midland, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR George Eichhorn | | 25C. FUNERAL DIRECTOR Lonaconing, Md. | |

SECRET

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]

1. [illegible]
2. [illegible]
3. [illegible]

4. [illegible]
5. [illegible]
6. [illegible]

7. [illegible]
8. [illegible]
9. [illegible]

10. [illegible]
11. [illegible]
12. [illegible]

13. [illegible]
14. [illegible]
15. [illegible]

16. [illegible]
17. [illegible]
18. [illegible]

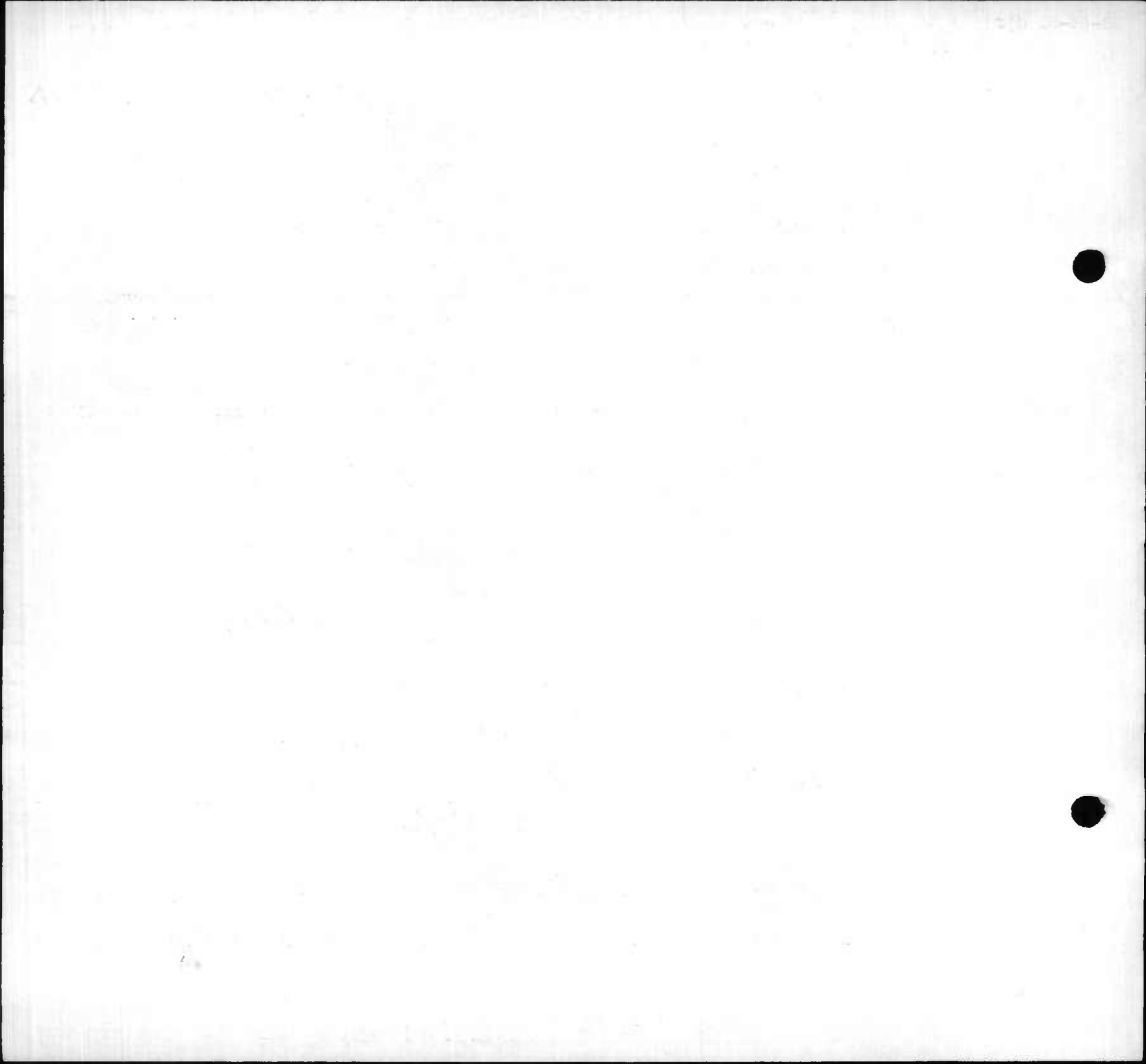
19. [illegible]
20. [illegible]
21. [illegible]

22. [illegible]
23. [illegible]
24. [illegible]

25. [illegible]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|----------------------|---|-----------------------------------|--|---|---|--|
| K-622 | | 72 07117 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07117 | |
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Verna Krzeszewski (Veronica) | | | | 2. DATE AND HOUR OF DEATH 7/27/72 7:30 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2605 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER 405 Gusryan Street 21224 | | | | | | | |
| 5. SEX Female | 6. RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/22/90 | 9. AGE (In years last birthday) 81 | 10. If Under 1 Yr. Months Days | | 11. If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Martin Setera | | | | 14. MOTHER'S MAIDEN NAME Agnes Lonczak | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. (220-44-7675) | | 17. INFORMANT 4940 Eastern Avenue BCH: RECORDS Baltimore, Maryland 21224 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 7/21/72 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrene of Abdomen 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No | | | | CAUSE OF DEATH Probable Pulmonary Embolus (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) edema of congestive heart failure DUE TO, OR AS A CONSEQUENCE OF: (C) carcinoma of bladder APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N.A. | | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) N.A. | | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? N.A. | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/13/72 19 72 to 7/27 19 72 and that (I) (we) last saw the deceased alive on 7/26 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Robert Franklin Draper, M.D. | | | | 23B. DATE SIGNED 7/27/72 | | 23C. PHYSICIAN'S NAME (Type) Robert Franklin Draper, M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 7/31/72 | | 24C. NAME of CEMETERY or CREMATORY St. Stanislaus Cemetery | |
| 24D. LOCATION Baltimore Maryland | | | | 24E. FUNERAL DIRECTOR R. F. Sadowski & Sons 1808 Eastern Ave | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | | | 25B. NAME OF REGISTRAR Audrey H. Hinton | | 25C. ADDRESS 1808 Eastern Ave | |



| D-200 | | 72 07118 | | STATE OF MARYLAND - DHMH BALTIMORE CITY HEALTH DEPARTMENT | | 72 07118 | |
|--|--|---|--|---|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | REG. NO. | |
| BIRTH NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) Joseph D. Diggs | | | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> July 26, 1972 M. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital (DOA) | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour July 26, 1972 12:50 P.M. | | | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1501 | | | |
| 6. SEX Male | | 7. RACE Negro | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH OCT 1929 | | 10. AGE (In years last birthday) 42 | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME JAMES DIGGS | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 15. MOTHER'S MAIDEN NAME ROSE ALTON | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT ROSE DIGGS | | ADDRESS 1438 MOUNTMOOR COURT | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E 8817X DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | CAUSE OF DEATH laceration of liver with intraperitoneal (A) IMMEDIATE CAUSE and retroperitoneal hemorrhage DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | | |
| 20A. DATE OF OPERATION 2 | | | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) vacant lot | | | |
| 22D. TIME OF INJURY (APPROX.) ? | | | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | |
| 22F. HOW DID INJURY OCCUR? Presumably accidentally fell | | | | 21. AUTOPSY? (Yes or No) Yes | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 27, 1972 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 7-31-72 | | 24C. NAME of CEMETERY or CREMATORY MOUNT AUBURN CEMETERY | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR Sandy [illegible] | | 25C. FUNERAL DIRECTOR MORTON & DYETT F. H. | | ADDRESS 1701 LAURENS | |

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) JAMES KNIGHT | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> July 26, 1972 | | Hour M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital (DOA) | | 3. DATE PRONOUNCED DEAD Month Day Year July 26, 1972 | | Hour M. 8:50 A. | |
| 6. SEX Male | | 7. RACE Negro | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH APRIL 7, 1905 | | 10. AGE (In years last birthday) 67 | | 11. BIRTHPLACE (State or foreign country) MARTINBURG, WEST VA. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME JAMES E. KNIGHT | | 14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1506 | |
| 15. MOTHER'S MAIDEN NAME EMMA BROWN | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 17. SOCIAL SECURITY NO. 212-05-8381-A | |
| 18. INFORMANT MRS. MABEL KNIGHT | | 19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | 20. DATE OF OPERATION 21. AUTOPSY? (Yes or No) No | |
| 22. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 23. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 24. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? | |
| 25. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 26. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 27. HOW DID INJURY OCCUR? | | 28. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | |
| 29. NAME OF REGISTRAR A. J. H. H. H. | | 30. FUNERAL DIRECTOR MORTON & DYETT F. H. | | 31. ADDRESS 1701 BAURENS ST. | |

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72 07120 STATE OF MARYLAND-DENVER
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07120

BIRTH NO.

REG. NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Lorenzo Gray | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 7 Day 26 Year 72 Hour M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital | | 3. DATE PRONOUNCED DEAD Month 7 Day 26 Year 72 Hour 1:10 a. | |
| 6. SEX male | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH MAY 15, 1948 | | 10. AGE (In years last birthday) 24 | |
| 11. BIRTHPLACE (State or foreign country) WHEELING, WEST VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME ERNEST GRAY | | 14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1801 | |
| 15. MOTHER'S MAIDEN NAME MABEL GRAY | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES | |
| 17. SOCIAL SECURITY NO. 579-58-8834 | | 18. INFORMANT SANDRA GRAY | |
| 19. CAUSE OF DEATH Shotgun wound of chest | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E9661X | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Restaurant | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Holiday Inn- 3600 Pulaski Hwy | | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 7 25 72 10:30 approx | |
| 22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Subject shot while apprehending suspect. | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/26/72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 7-29-72 | |
| 24C. NAME OF CEMETERY or CREMATORY HARMONY CEMETERY | | 24D. LOCATION (City, town, or county) (State) WASHINGTON, D. C. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR Audrey Johnson | |
| 25C. FUNERAL DIRECTOR MROTON & DYETT F. H. | | ADDRESS 1701 LAURENS ST. | |

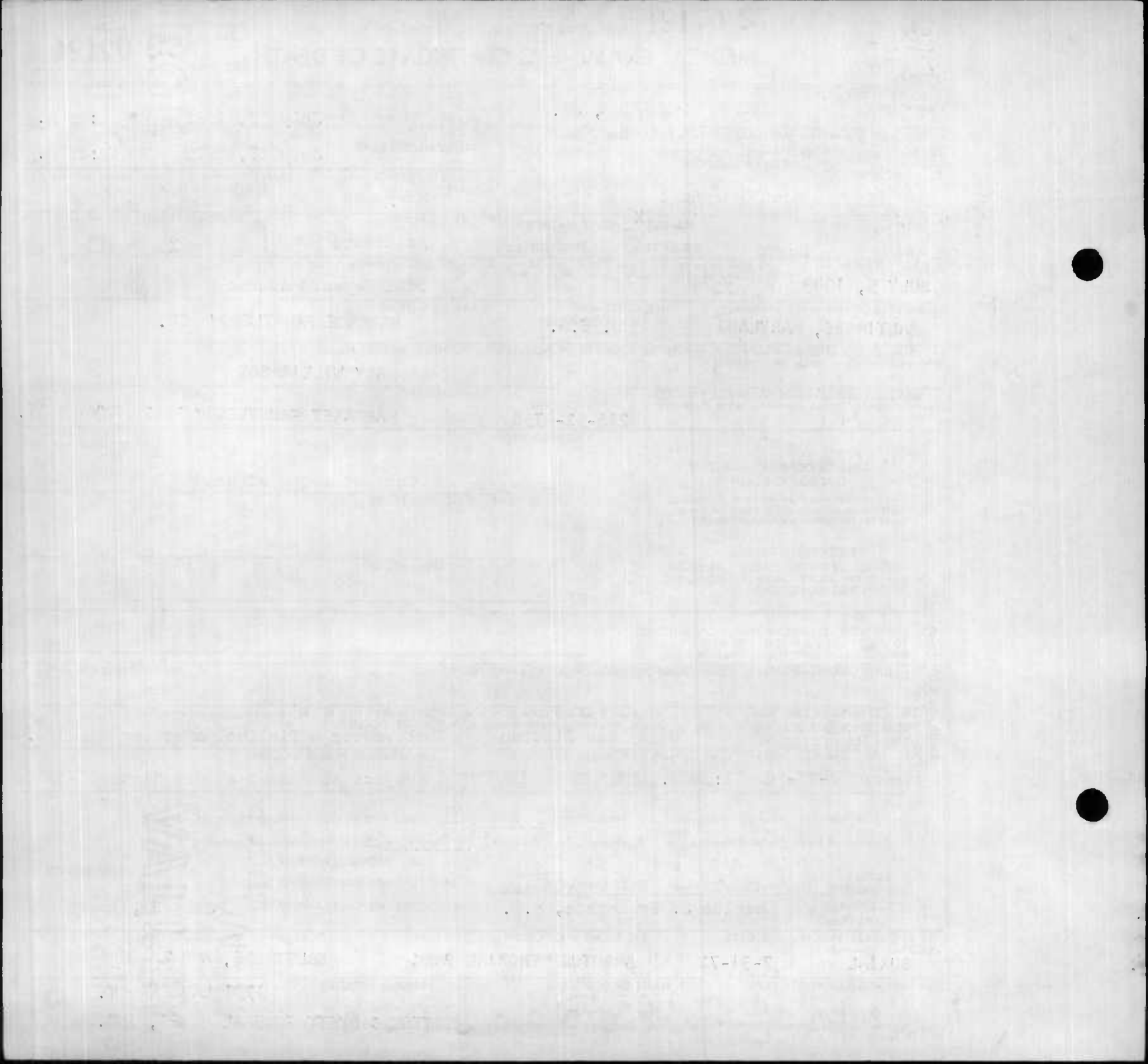
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07121

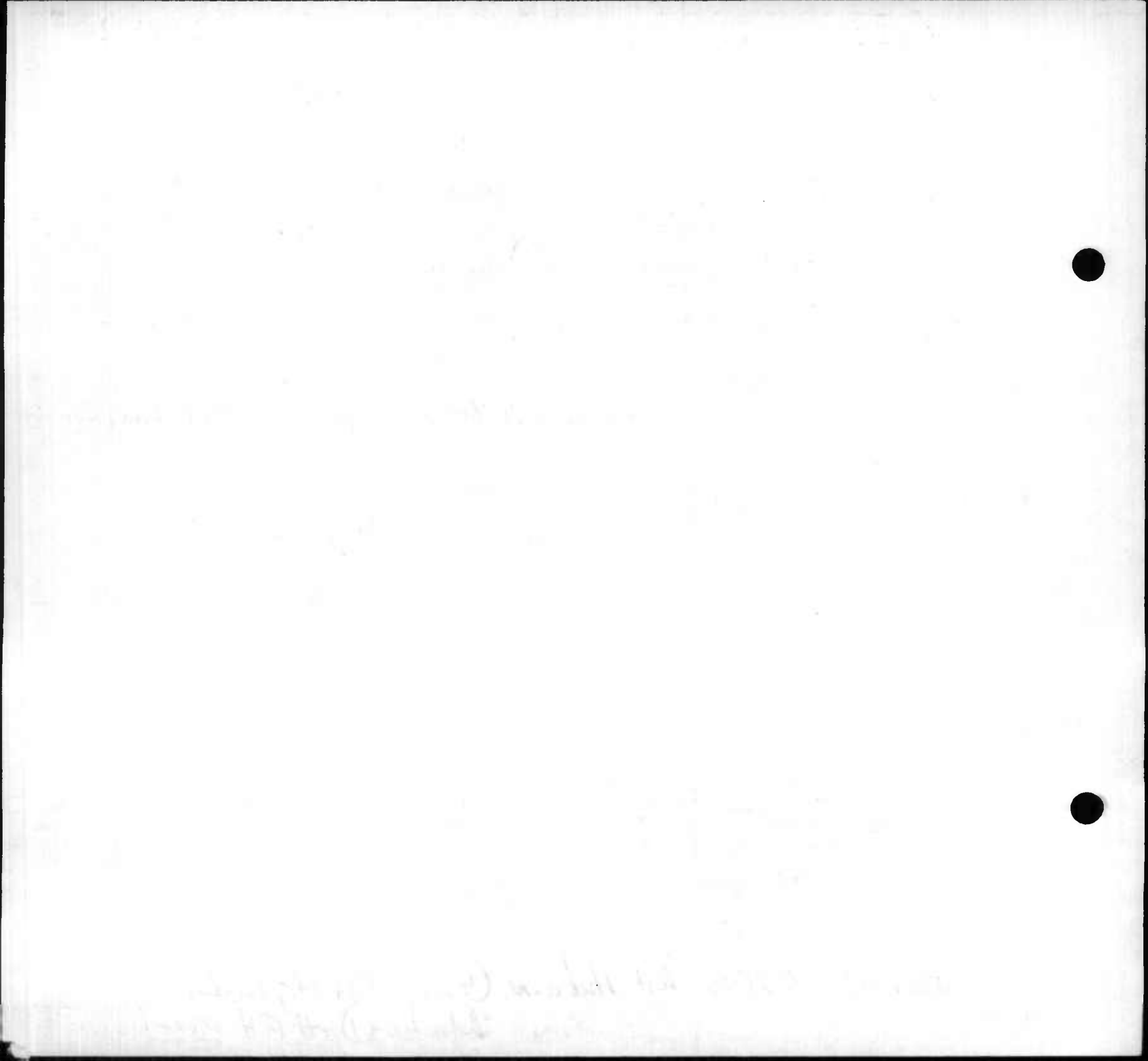
BIRTH NO.

| | | | |
|---|---|---|--|
| 1. NAME OF DECEASED (Type or Print) HORACE FAUNTLEROY, JR. | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> July 27, 1972 12:15 A.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year July 27, 1972 12:15 A.M. | |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2788 | | | |
| 6. SEX Male | 7. RACE Negro | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 9. DATE OF BIRTH JULY 5, 1949 | 10. AGE (In years lost birthday) 23 | E. STREET AND NUMBER 3802 Hayward Avenue | |
| 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 15. MOTHER'S MAIDEN NAME MARY WILLIAMSON | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. 216-52-4758 | |
| 18. INFORMANT MARGARET FAUNTLEROY | | ADDRESS 3802 HAYWARD ST. | |
| 19. E9651X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Gunshot wound of head (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Gas Station | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Belevedere & Pinlico "American Gas Sta." | | 22D. TIME OF INJURY (Approx.) 7-26-72 11:50 P.m. | |
| 22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Subject attendant at Gas Station - shot during hold-up | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 27, 1972 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 7-31-72 | 24C. NAME of CEMETERY or CREMATORY ARBUTUS MEMORIAL PARK | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | 25B. NAME OF REGISTRAR Lidney | 25C. FUNERAL DIRECTOR 1701 LAURENS ST. MORTON & OYETT FUNERAL HOMES, INC. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

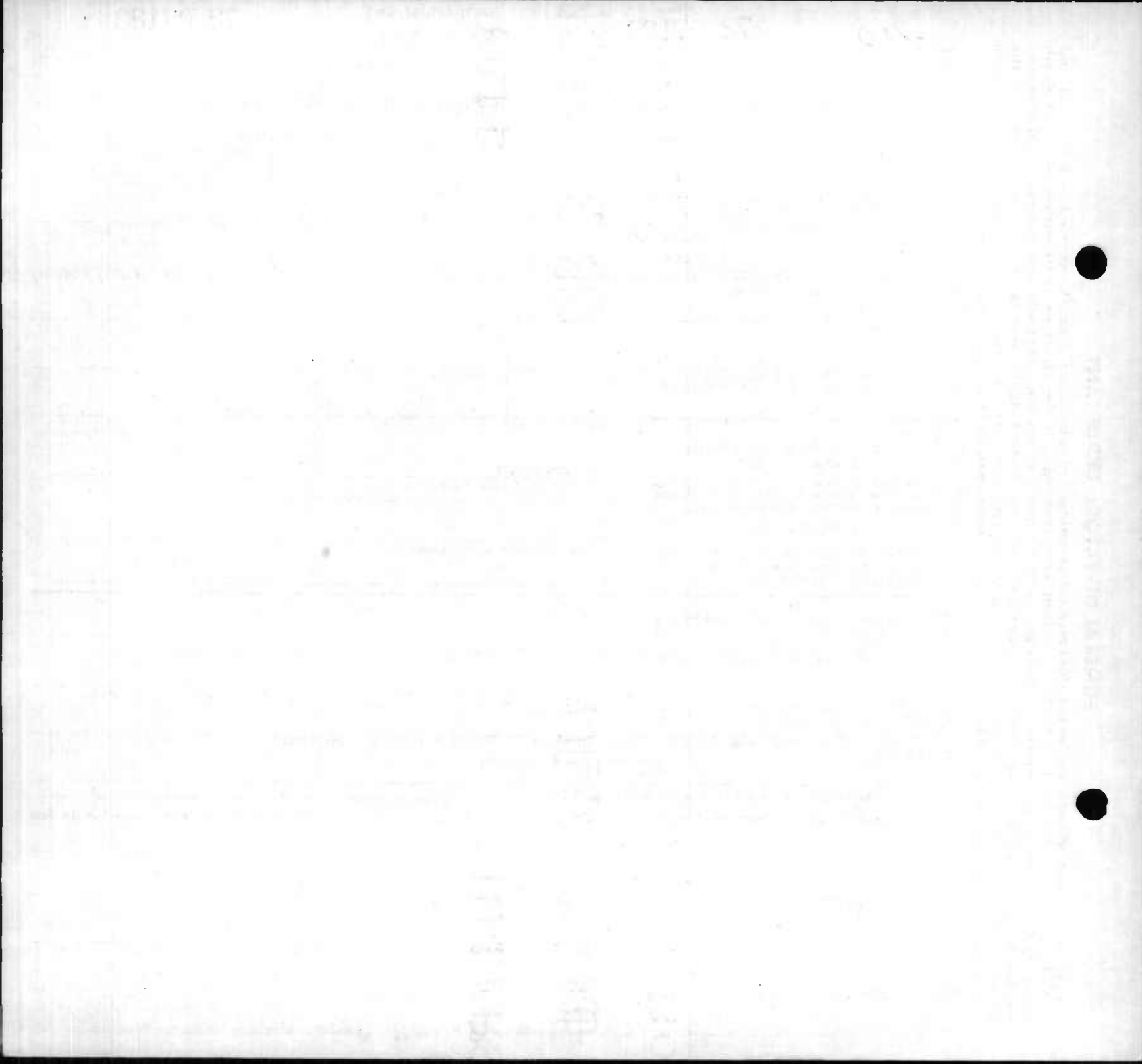
| | | | | | | | |
|--|--------------|---|------------------------------|--|-----------------------|---|----------------------|
| H-630 | | 72 07122 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07122 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | REG. NO. | | STATE OF MARYLAND - DEATH | |
| 1. NAME OF DECEASED (Type or Print) HARDY, Thelma D. | | | | 2. DATE AND HOUR OF DEATH 7-24-72 9:44 AM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bon Secours Hospital 2025 W. Fayette STREET BALTIMORE, Md. 21223 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1602 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 700 N. Carey STREET 21217 | | | |
| 5. SEX F | 6. RACE N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-13-30 | 9. AGE (In years last birthday) 41 | If Under 1 Yr. Months | If Under 24 Hrs. Days | If Under 1 Yr. Hours |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Work as maid | | 10B. KIND OF BUSINESS OR INDUSTRY House keeping | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME FRANK Washington | | | | 14. MOTHER'S MAIDEN NAME Margaret Hardy | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 215-26-7831 | | 17. INFORMANT Hattie Simpkins | | ADDRESS -1817-W. LANVALE ST | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION 486X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Pneumonia Rt lung. Hyperpyrexia 5 days DUE TO, OR AS A CONSEQUENCE OF: (C) | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION 7-23-72 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (X) (this hospital) attended the deceased from 7-23-1972 to 7-24-1972 that (X) (we) last saw the deceased alive on 7-24-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Bhangare | | | | 23B. DATE SIGNED 7-24-72 | | | |
| 23C. PHYSICIAN'S NAME (Type) Usha Bhangare | | | | 23D. ADDRESS Bon Secours Hosp. Baltimore Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-28-72 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR Alicia [unclear] | | 25C. FUNERAL DIRECTOR Morton Dyett F.H. | | ADDRESS 1701- [unclear] ST. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

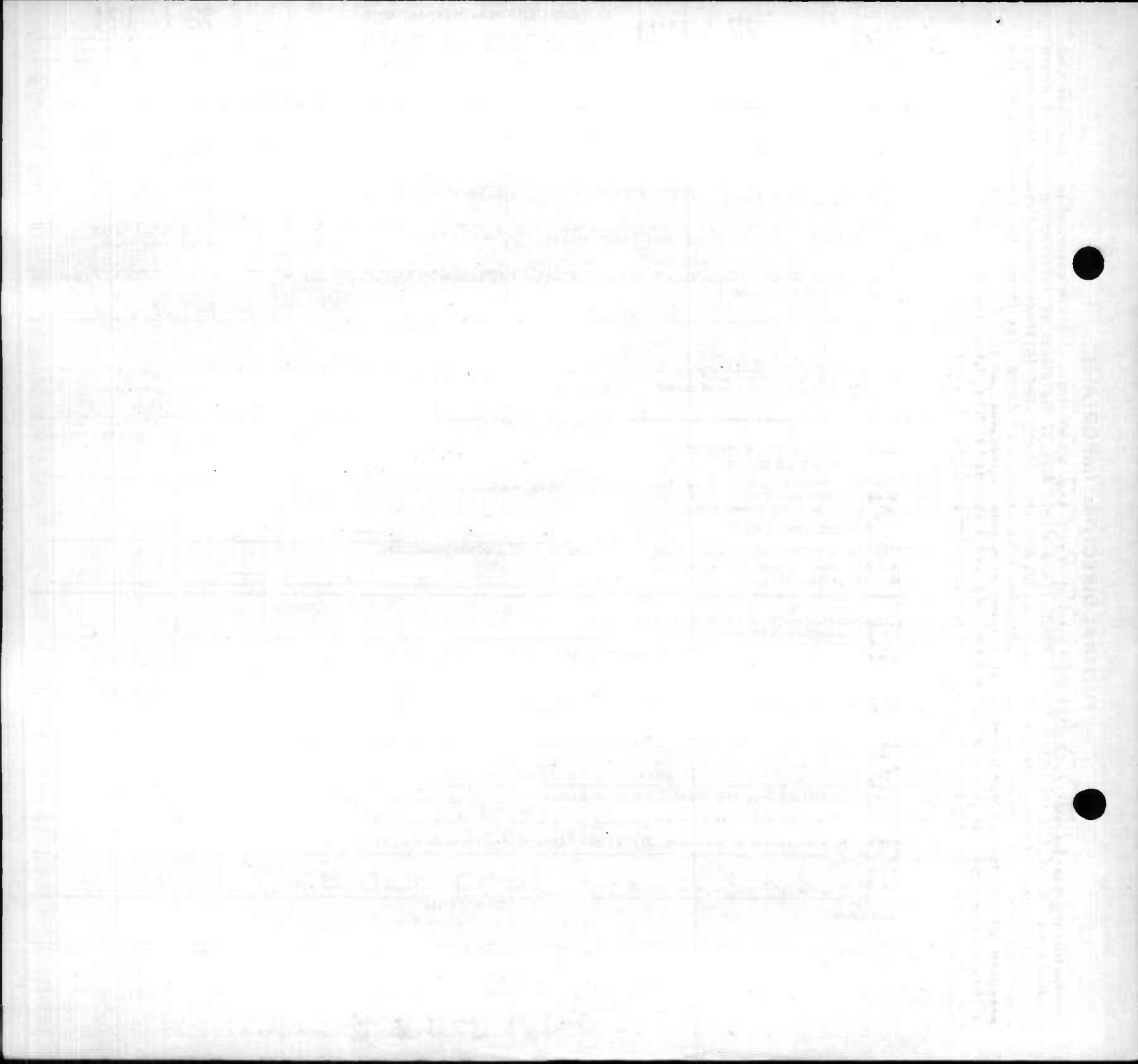
| | | | | | | | | | |
|--|-------------------------|---|-----------------------------------|---|--|--|---|--|--|
| S-160 | | 72 07123 | | Baltimore City Health Department | | X | | REG. NO. 72 07123 | |
| BIRTH NO. | | NAME OF DECEASED (Type or Print) <i>Schaeffer, George</i> | | | | DATE AND HOUR OF DEATH <i>July 20, 1972 3:30 p.m.</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | | | | 5. CITY OR TOWN <i>Brooklandville</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>44 Union Memorial Hospital 3301 N. CALVERT STREET Baltimore, Md 21218</i> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | E. STREET AND NUMBER <i>Greenspring Valley Road</i> | | | | | |
| 5. SEX <i>Male</i> | 6. RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>3-4-02</i> | 9. AGE (In years last birthday) <i>70</i> | 10. If Under 1 Yr. Months: Days: Hours: Min. | 11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i> | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME <i>ROBERT SCHAEFFER (D)</i> | | 14. MOTHER'S MAIDEN NAME <i>Annah Stark (D)</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>None</i> | | 16. SOCIAL SECURITY NO. <i>215-32-0408</i> | | 17. INFORMANT <i>Mrs. Nellie K. Schaeffer, Brooklandville</i> | |
| 18. <i>441.21</i> | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>RUPTURE OF ABDOMINAL ANEURYSM.</i> | | | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <i>CHRONIC HYPERTENSION</i> DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | <i>CHRONIC HYPERTENSION</i> | | | | | | | |
| 19A. DATE OF OPERATION <i>July 20, 1972</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>RUPTURE OF ABD. ANEURYSM.</i> | | 20A. AUTOPSY? (Yes or No) <i>YES</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>July 20</i> 19 <i>72</i> to <i>July 20</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>July 20</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE <i>Howard T. Scheel</i> | | 23B. DATE SIGNED <i>July 20/1972</i> | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS <i>UNION MEMORIAL HOSPITAL</i> | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL, (Specify) | | 24B. DATE <i>July 24, 1972</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Staten Island Baptist Church</i> | | 24D. LOCATION (City, town, or county) (State) <i>Staten Island, N.Y.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JUL 28 1972</i> | | 25B. NAME OF REGISTRAR <i>Andrew H. Norton</i> | | 25C. FUNERAL DIRECTOR <i>Frank J. Neri, Baltimore, Md.</i> | | ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

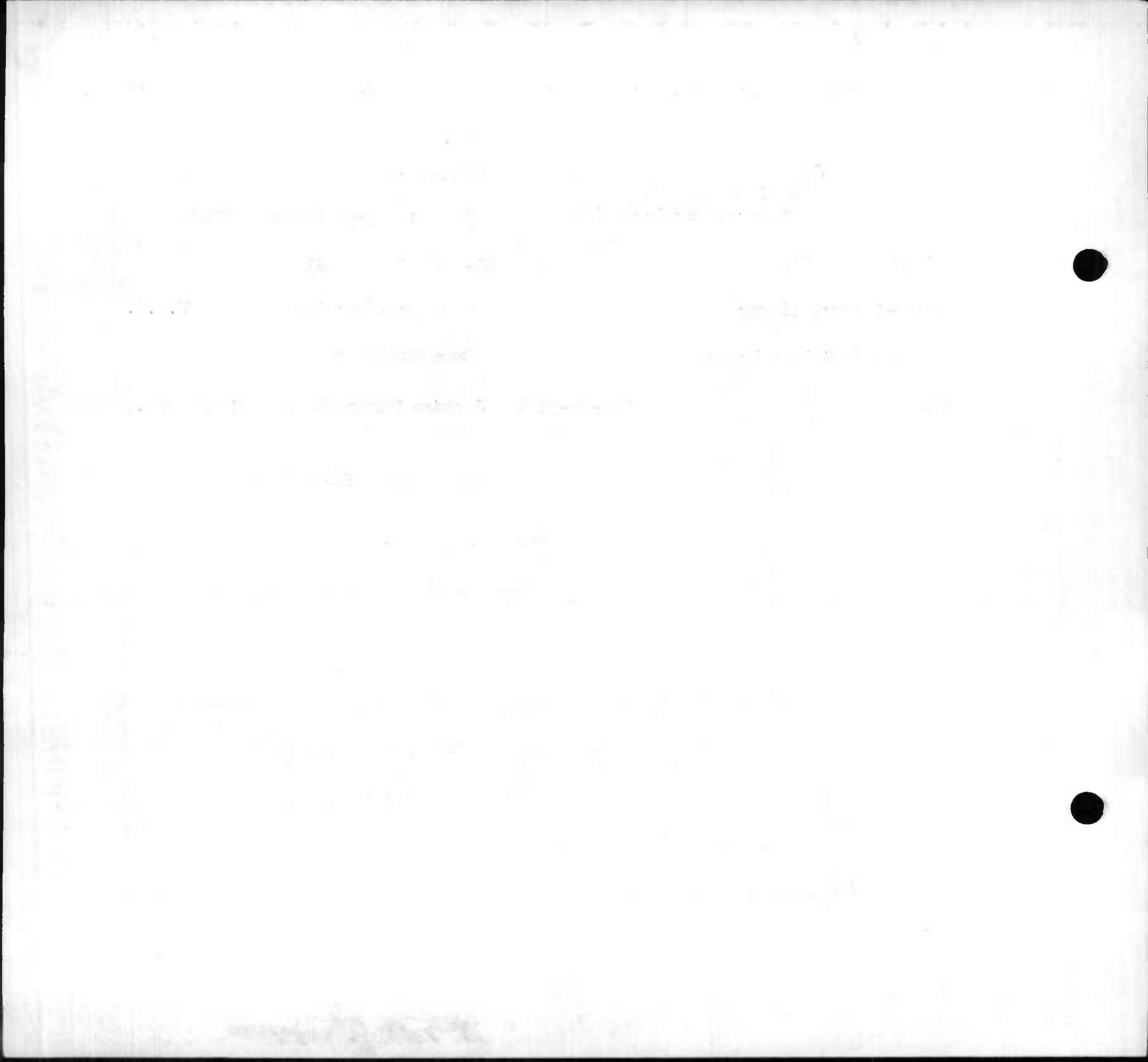
| | | | |
|---|------------------|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07124 | |
| G-000 72 07124 | | X CERTIFICATE OF DEATH | |
| BIRTH NO. 72 07124 | | STATE OF MARYLAND-DHME | |
| 1. NAME OF DECEASED (Type or Print) GUE, JENNIE | | 2. DATE AND HOUR OF DEATH 7/25/72 10:45 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD M.D. GEN. HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Md. GENERAL HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY BALTO C. CITY OR TOWN Baltimore 8 D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 728 Suddbrook Lane | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug 29, 1893 9. AGE (In years last birthday) 78 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY OWN HOME | |
| 11. BIRTHPLACE (State or foreign country) Savannah, Ga. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Alexander Johnston | | 14. MOTHER'S MAIDEN NAME Louisa Hernandez | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mrs. Leon Victor Gue, 728 Suddbrook Lane | | ADDRESS Pikesville 8, Md. | |
| 18. 485X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) STAPHYLOCOCCAL EMPYEMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Septicemia Broncho-pneumonia Dehydration | | CAUSE OF DEATH STAPHYLOCOCCAL EMPYEMA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/20/71 19 to 7/25/71 19 that (I) (we) last saw the deceased alive on 7/25/71 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Raymond A. Vo. H. M.D. | | 23B. DATE SIGNED 7/25/72 | |
| 23C. PHYSICIAN'S NAME (Type) Raymond A. Vo. H. | | 23D. ADDRESS Pikesville 8, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE July 28 1972 | |
| 24C. NAME OF CEMETERY OR CREMATORY Wicklow Swamp Cemetery | | 24D. LOCATION (City, town, or county) (State) Norway, South Carolina | |
| 25A. DATE REC'D BY HEALTH DEPT. July 28 1972 | | 25B. NAME OF REGISTRAR Arlene Wilson | |
| 25C. FUNERAL DIRECTOR Frank H. Newell, Pikesville 8, Md. | | ADDRESS Pikesville 8, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

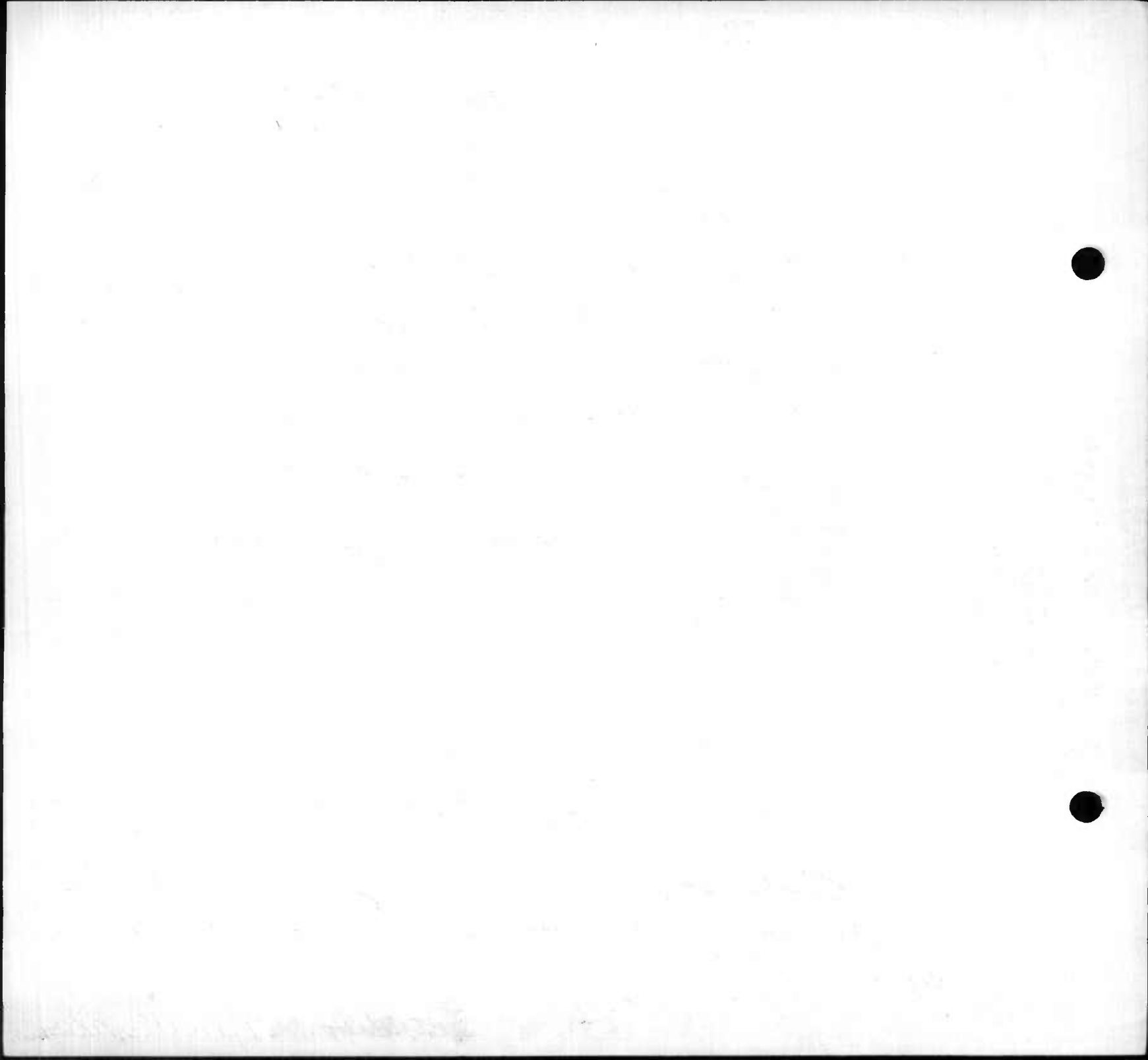
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07125 | | CERTIFICATE OF DEATH | | REG. NO. 72 07125 | | STATE OF MARYLAND-DEMH | |
|---|--|---|--|---|--|---|--|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Miss Emma Irene Kenney | | | | 2. DATE AND HOUR OF DEATH 7-24-72 5:15 P.M. | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 91 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Jenkins Memorial Hospital 1000 Caton Avenue Baltimore, Maryland 21229 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1511 | | | | | | | |
| | | | | 5. CITY OR TOWN Baltimore | | 6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| | | | | 7. STREET AND NUMBER 3500 Callaway Avenue 21215 | | | | | | | |
| 5. SEX Female | | 6. RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11-30-1878 | | 9. AGE (in years last birthday) 93 | | 10. Under 1 Yr. Months Days If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse-Concert Singer | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Edward McGolgan Kenney | | | | 14. MOTHER'S MAIDEN NAME Emma Stembler | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown | | | | 16. SOCIAL SECURITY NO. 216-54-5271 | | 17. INFORMANT Jenkins Memorial 1000 Caton Ave., 21229 | | | | ADDRESS | |
| 18. 4-12-4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| | | | | (A) IMMEDIATE CAUSE Cardiac Arrhythmia DUE TO, OR AS A CONSEQUENCE OF: | | | | minutes | | | |
| | | | | (B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: | | | | years | | | |
| | | | | (C) generalized atherosclerosis DUE TO, OR AS A CONSEQUENCE OF: | | | | years | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | | | | | |
| | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (A) (this hospital) attended the deceased from 2/13 1960 to 7/24 1972 that (I) (we) last saw the deceased alive on 7/24 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE J. Raymond Gladen | | | | 23B. DATE SIGNED 7/29/72 | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | | | |
| Burial | | July 26 1972 | | New Catholic Church, Baltimore | | Baltimore | | Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR Lidney | | 25C. FUNERAL DIRECTOR NEWELL'S P.H. | | 25D. ADDRESS | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | | | | |
|--|---------|---|------------------|--|--|--|-----------------------------------|---------------|---|------------------------------|
| S-365 | | 72 07126 | | BALTIMORE CITY HEALTH DEPARTMENT | | X | | 72 07126 | | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | | | REG. NO. STATE OF MARYLAND-DHM | | | | |
| 1. NAME OF DECEASED (Type or Print) | | Stromberg, Ada Bell | | | | 2. DATE AND HOUR OF DEATH 7-24-72 5 P.M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY | | | | 5. C. CITY OR TOWN D. INSIDE CITY LIMITS? | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | Maryland | | | | 5300 | | | | |
| Bolton Hill Nursing Home | | Dwings Mills | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 1400 John St. | | 9 Lastgate Rd. | | | | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (in years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
| F | W | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8/16/84 | 87 | HOUSEWIFE | OWN HOME | | MARYLAND | U.S.A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS |
| Charles Taylor | | Laura Miles | | No | | NONE | | 220-05-8500 | | Admission Record |
| 18. 412.3 I | | CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | yes | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | yes | | | | |
| ANTECEDENT CAUSES | | (C) | | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last. | | | | | | | | | | |
| II | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | |
| | | | | | | | | | | |
| 21D. TIME OF INJURY (Approx.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from | | 2/3 | | 19 66 to | | 7/27 | | 19 72 | | |
| that (I) (we) last saw the deceased alive on | | 7/24 | | 19 72 | | and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | | |
| [Signature] | | 7/26/72 | | [Signature] | | 23D. ADDRESS | | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | | |
| Burial | | 7/27 | | Korraine Park Cemetery | | Woodlawn | | MD | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | | |
| JUL 28 1972 | | [Signature] | | [Signature] | | Newell's, Baltimore | | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07127

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Lula Anderson | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 7 26 72 M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 5513 Gwynn Oak Avenue | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 26 72 3:00 a. M. | |
| 6. SEX female | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 12/25/03 | | 10. AGE (In years lost birthday) 68 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) PA. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 15. MOTHER'S MAIDEN NAME Susie | | E. STREET AND NUMBER 5513 Gwynn Oak Avenue | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 213-03-7414 | |
| 18. INFORMANT Alice Lieslia | | ADDRESS 5513 Gwynn Oak Ave. | |
| 19. CAUSE OF DEATH Hypertensive and arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (C) | |
| 20A. DATE OF OPERATION 8/1/72 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22D. TIME (Month) (Day) (Year) (Hour) (Approx.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. EXAMINER'S NAME (Type) DATE SIGNED 7/26/72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/1/72 | |
| 24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park | | 24D. LOCATION (City, town, or county) (State) Arbutus Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR Andrew Johnson | |
| 25C. FUNERAL DIRECTOR Charles A. Rice | | ADDRESS 1300 Eutaw Place | |

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WASHINGTON, D. C. 20250

FOURTH DISTRICT

ALBUQUERQUE, NEW MEXICO

OFFICE OF THE DISTRICT MANAGER

1000 EAST UNIVERSITY AVENUE

ALBUQUERQUE, N. M. 87102

TELEPHONE (505) 261-6100

TELETYPE (505) 261-6100

FACSIMILE (505) 261-6100

MAIL ROOM (505) 261-6100

RECORDS SECTION (505) 261-6100

PLANNING SECTION (505) 261-6100

INSPECTION SECTION (505) 261-6100

LEGAL COUNSEL (505) 261-6100

ADMINISTRATIVE SERVICES (505) 261-6100

GENERAL INVESTIGATIVE DIVISION (505) 261-6100

LABORATORY (505) 261-6100

TRAINING CENTER (505) 261-6100

RESEARCH CENTER (505) 261-6100

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72 07128

STATE OF MARYLAND-DEMD
BALTIMORE CITY HEALTH DEPARTMENT

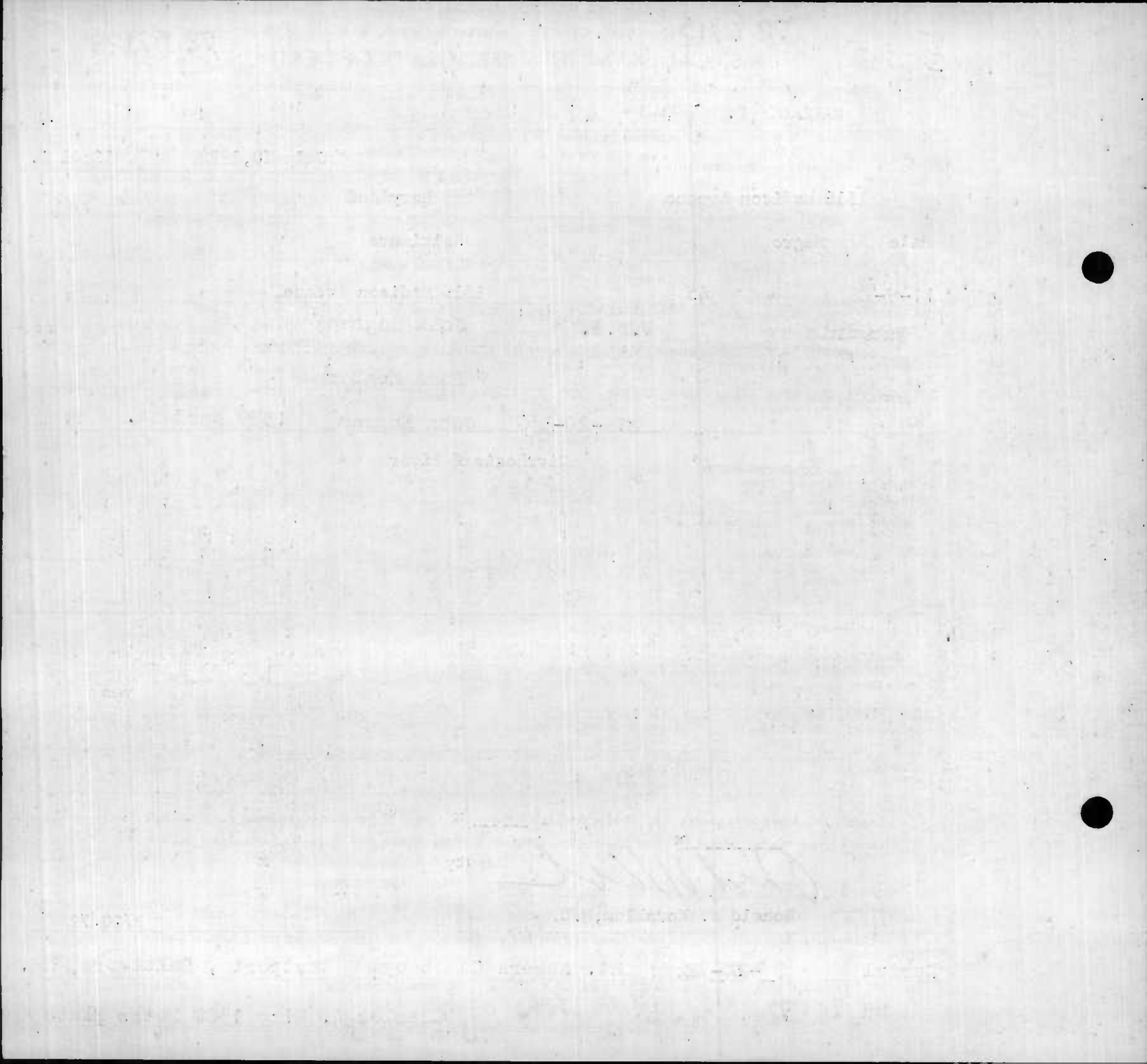
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07128

REG. NO.

BIRTH NO.

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) WALLACE T. ENGRAM | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1516 Madison Avenue | | 3. DATE PRONOUNCED DEAD Month Day Year Hour July 20, 1972 12:01 P.M. | |
| 6. SEX Male | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 11-9-26 | | 10. AGE (In years last birthday) 45 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 216-20-5575 | |
| 18. INFORMANT John Engram | | ADDRESS 1339 Ward St. | |
| 19. CAUSE OF DEATH Cirrhosis of liver | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (C) | |
| 20A. DATE OF OPERATION 7-21-72 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Ronald N. Kornblum, M.D. | | Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-24-72 | |
| 24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State) Westport, Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR Adrian Whitson | |
| 25C. FUNERAL DIRECTOR Charles A. Rice | | ADDRESS 1300 Eutaw Place | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07129

REG. NO.

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) James C. Fisher | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 468 Oxford Ct. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour M. 7 21 72 8:30 p. | |
| 6. SEX male | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 3/18/34 | | 10. AGE (In years lost birthday) 38 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Sterlings Fisher | | 14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1702 | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 15. MOTHER'S MAIDEN NAME Carrie Lee Smith | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 17. SOCIAL SECURITY NO. 215-30-6718 | | 18. INFORMANT ADDRESS Carrie Lee Rideout 468 Oxford Ct | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute alcoholism ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Acute alcoholism OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Marvin Platt M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Marvin Platt, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7/22/72 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/27/72 | |
| 24C. NAME of CEMETERY or CREMATORY Bush Park | | 24D. LOCATION (City, town, or county) (State) Cooksville, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR Lidney Ingham | |
| 25C. FUNERAL DIRECTOR ADDRESS Charles A. Rice 1300 Eutaw Pl. | | | |

WALLACE V. FRONZ

NEW-BAY BOOKS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|-------------------------|---|--|---|---|---|--|
| W-630 | | 72 07130 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07130 | |
| BIRTH NO. | | | | STATE OF MARYLAND - DHMH | | | |
| 1. NAME OF DECEASED (Type or Print) ELIZABETH WARD | | | | 2. DATE AND HOUR OF DEATH 7/26/72 1045 A M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2201 | | | |
| | | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 107 W LEE ST | | | |
| 5. SEX FEMALE | 6. RACE BLACK | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/1/07 | 9. AGE (In years last birthday) 65 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) UNKNOWN | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME UNKNOWN | | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT PATIENT | | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH SEPTIC SHOCK (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BILATERAL PNEUMONIA (B) DUE TO, OR AS A CONSEQUENCE OF: (C) — | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hrs 24 hrs | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). SEVERE MALNUTRITION + DEHYDRATION | | | | | | | |
| 19A. DATE OF OPERATION 7/26/72 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20A. AUTOPSY? (Yes or No) NO YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? — | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) — | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) — | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? — | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/22 19 72 to 7/26 19 72 that (I) (we) last saw the deceased alive on 7/22 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Paul Douglas Light M.D. | | | | 23B. DATE SIGNED 7/26/72 | | 23C. PHYSICIAN'S NAME (Type) PAUL DOUGLAS LIGHT M.D. | |
| 23D. ADDRESS UNIVERSITY HOSPITAL | | 23E. NAME OF REGISTRAR Charles A. Rice | | | | | |
| 24A. BURIAL CREMATION, (Specify) BURIAL | | 24B. DATE 7/29/72 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem. | | 24D. LOCATION (City, town, or county) (State) Brooklyn, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR Sidney H. Hinton | | 25C. FUNERAL DIRECTOR ADDRESS Charles A. Rice 1300 Eutaw Place | | | |

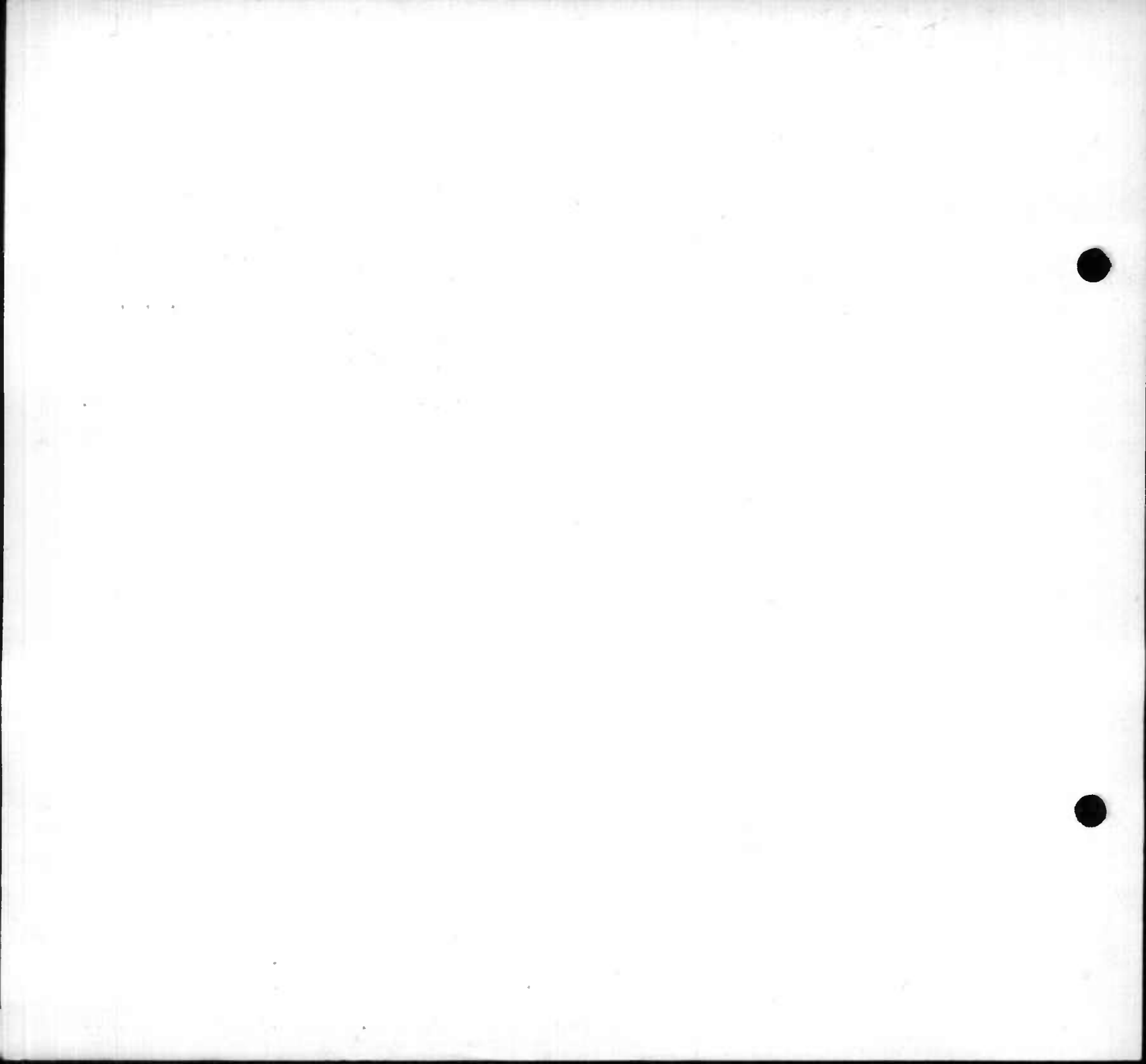
1042A

5/50/75

ELIZABETH WARD

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|---|--|---|
| <p style="font-size: 24pt; margin: 0;">72 07131</p> <p style="font-size: 12pt; margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 24pt; margin: 0;">72 07131</p> <p style="font-size: 12pt; margin: 0;">REG. NO. STATE OF MARYLAND=DHMH</p> | | | |
| <p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) <u>LELA DIXON</u></p> | | <p>2. DATE AND HOUR OF DEATH</p> <p><u>7:30AM JULY 25/72</u></p> | |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><u>LUTHERAN HOSPITAL OF MARYLAND</u></p> | | <p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)</p> <p>A. STATE <u>MARYLAND</u> B. COUNTY <u>1605</u></p> <p>C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>W. FRANKLIN ST. 2646</u></p> | |
| <p>5. SEX</p> <p><u>F</u></p> | <p>6. RACE</p> <p><u>BLACK</u></p> | <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> | <p>8. DATE OF BIRTH</p> <p><u>7-1-1907</u></p> |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> | | <p>11. BIRTHPLACE (State or foreign country)</p> <p><u>South Carolina</u></p> | |
| <p>13. FATHER'S NAME</p> <p><u>Simms Johnson</u></p> | | <p>14. MOTHER'S MAIDEN NAME</p> <p><u>Mary Booser</u></p> | |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> | | <p>16. SOCIAL SECURITY NO.</p> | |
| <p>15. INFORMANT</p> <p><u>Rebecca Oliver 2646 Franklin St.</u></p> | | <p>ADDRESS</p> | |
| <p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><u>4361</u></p> <p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARDIORESPIRATORY FAILURE ARREST</u></p> <p>(B) <u>SEPTICEMIA & RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) <u>CVA</u></p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,</p> | | <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> | |
| <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p> | | | |
| <p>19A. DATE OF OPERATION</p> | | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> | |
| <p>20A. AUTOPSY? (Yes or No)</p> <p><u>NO</u></p> | | <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)</p> | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | |
| <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | | <p>21D. TIME OF INJURY (APPROX.)</p> | |
| <p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | | <p>21F. HOW DID INJURY OCCUR?</p> | |
| <p>22. I certify that (I) (this hospital) attended the deceased from <u>7-8-72</u> 19<u>72</u> to <u>7-25</u> 19<u>72</u> that (I) (we) last saw the deceased alive on <u>7-25</u> 19<u>72</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | | | |
| <p>23A. SIGNATURE</p> <p><u>Manning</u></p> | | <p>23B. DATE SIGNED</p> <p><u>July 25/72</u></p> | |
| <p>23C. PHYSICIAN'S NAME (Type)</p> <p><u>RUBEN MAURIQUEZ</u></p> | | <p>23D. ADDRESS</p> <p><u>LUTHERAN HOSPITAL OF MARYLAND</u></p> | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p><u>Burial</u></p> | | <p>24B. DATE</p> <p><u>7/29/72</u></p> | |
| <p>24C. NAME OF CEMETERY or CREMATORY</p> <p><u>Arbutus Mem. Park</u></p> | | <p>24D. LOCATION (City, town, or county) (State)</p> <p><u>Arbutus, Maryland</u></p> | |
| <p>25A. DATE REC'D BY HEALTH DEPT.</p> <p><u>JUL 28 1972</u></p> | | <p>25B. NAME OF REGISTRAR</p> <p><u>Dr. J. H. Johnson</u></p> | |
| <p>25C. FUNERAL DIRECTOR</p> <p><u>Charles A. Rice</u></p> | | <p>ADDRESS</p> <p><u>1300 Eutaw Place</u></p> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07132 | |
|---|--|--|--|--|--|
| C-620 72 07132 | | | | STATE OF MARYLAND-DHMH | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Dennis Creek | | 7/25/72 6:10 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | | | |
| 00 1427 Ward St. | | Maryland | | | |
| | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER | | | |
| | | 1427 Ward St. | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| Male | Colored | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 4/16/11 | 61 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
| | | | | Maryland | U.S.A. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| James Creek | | | Elizabeth Johnson | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | Viola Phillips 1427 Ward St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4/12/31 | | Arteriosclerotic Heart | | 3 weeks | |
| ANTECEDENT CAUSES | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | DISEASE WITH FAILURE | | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | Hypertension of Prostate | | 3 years | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/24 1967 to 7/25 1972, that (I) (we) lost saw the deceased alive on 7/24 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| James P. Urlock Jr. MD | | | | 7/28/72 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| JAMES P. URLOCK JR. MD | | 1227 W. Wm. Blvd Baltimore Md. 41230 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | 7/29/72 | Mt. Auburn Cem. | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JUL 28 1972 | | Charles A. Rice | | 1300 Eutaw Pl. | |

50th St

50th St

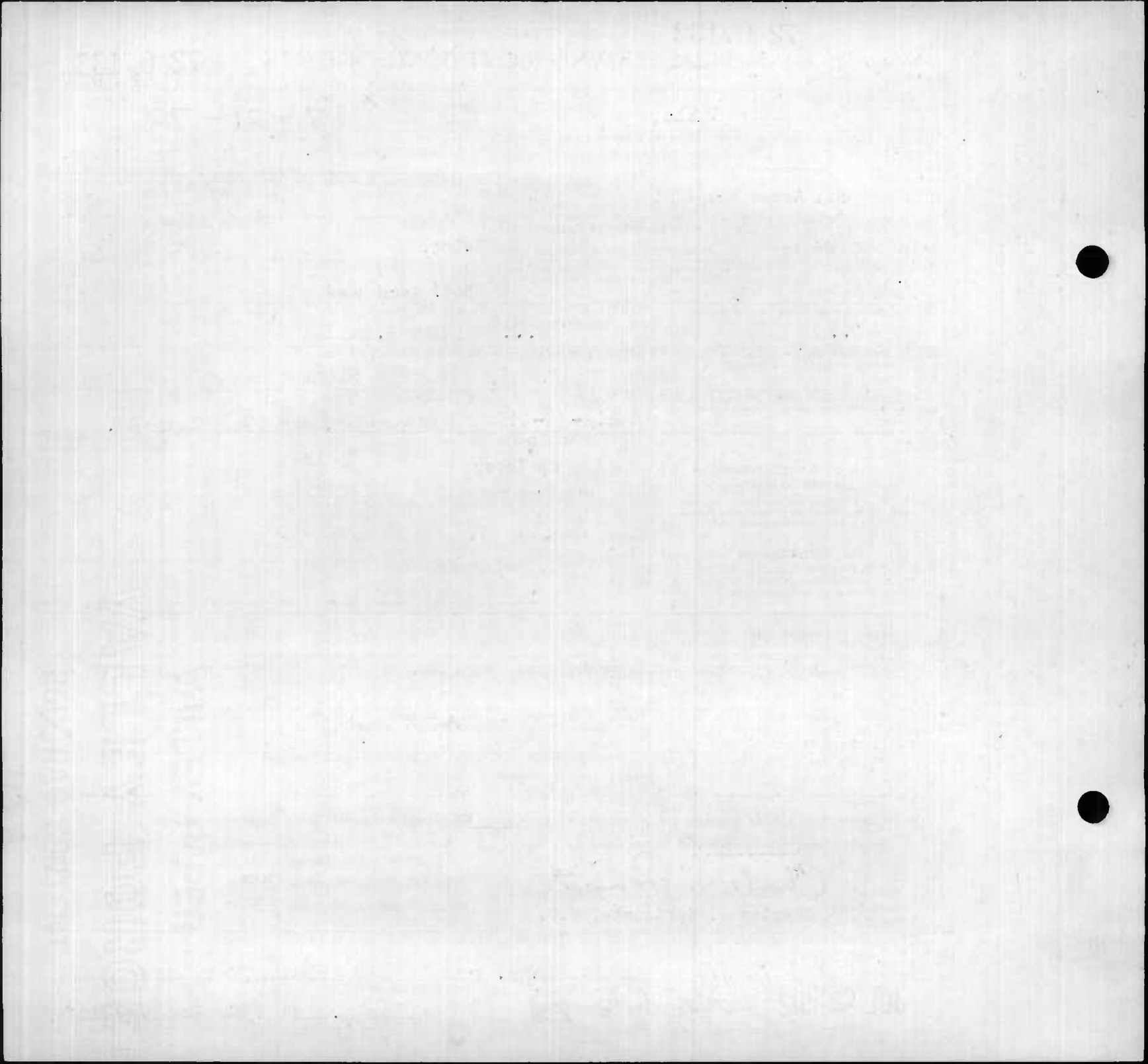
72 07133

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07133

BIRTH NO.

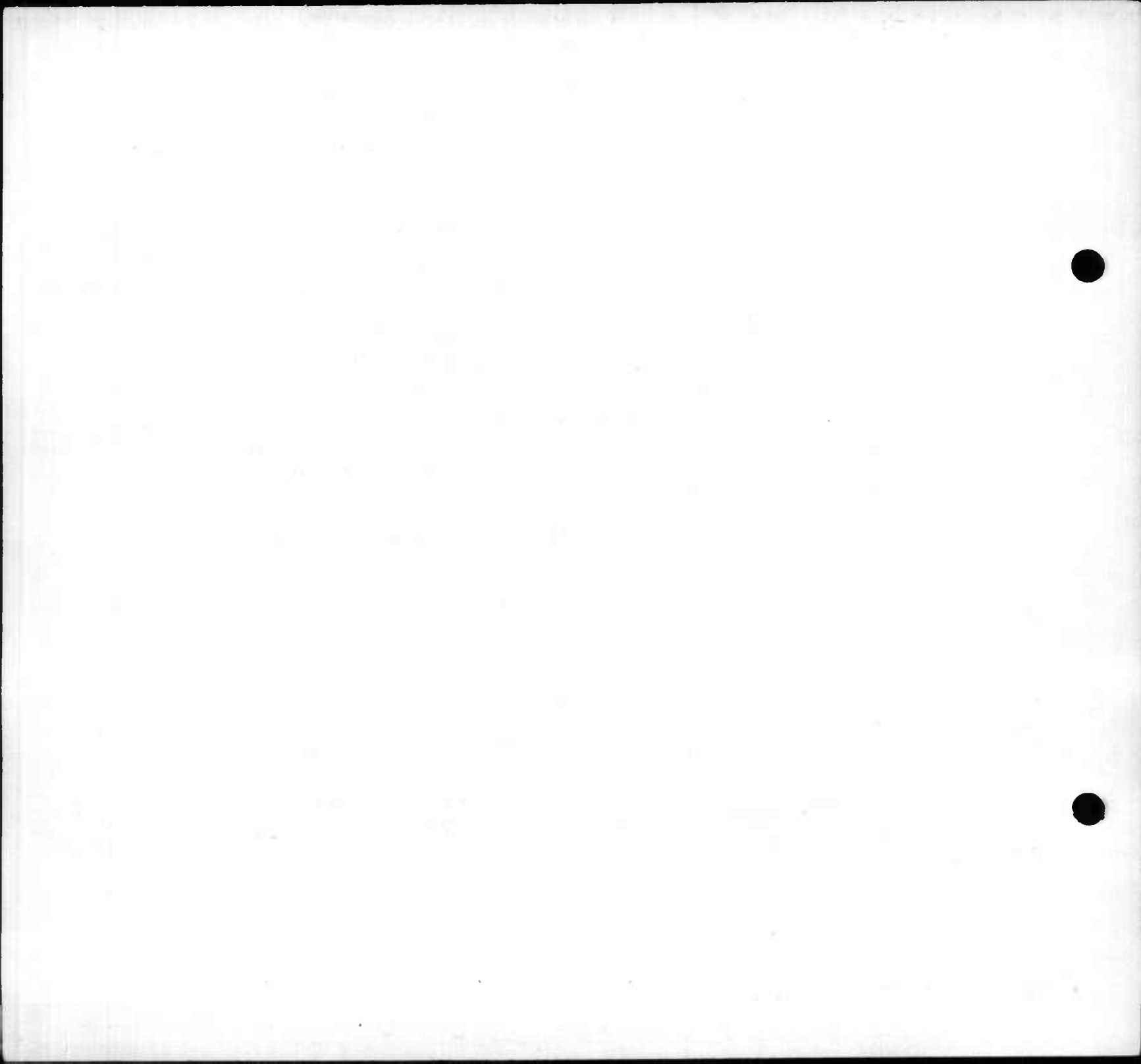
| | | | | |
|---|--|---|---|--|
| 1. NAME OF DECEASED (Type or Print) Daniel Dailey | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> 7-21-72 | | Hour M. |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 21 72 8:40 p. | | M. |
| 6. SEX male | | 7. RACE Negro | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH 4/30/34 | | 10. AGE (In years last birthday) 38 | 11. BIRTHPLACE (State or foreign country) Md.. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME John R. Dailey | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| 15. MOTHER'S MAIDEN NAME Carrie Simms | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 213-32-4194 |
| 18. INFORMANT Barbara Dailey | | 19. CAUSE OF DEATH Epilepsy | | 20. ADDRESS 5743 Race Rd. |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Epilepsy | | 20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II | | 21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) yes |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) | | M.D. Charles S. Springate, M.D. | | DATE SIGNED 7/22/72 |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/26/72 | | 24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park |
| 24D. LOCATION (City, town, or county) Arbutus, Maryland | | 24E. NAME of REGISTRAR Arbutus, Maryland | | 24F. FUNERAL DIRECTOR Charles A. Rice |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 28 1972 | | 25B. NAME OF REGISTRAR Arbutus, Maryland | | 25C. FUNERAL DIRECTOR ADDRESS 1300 Eutaw Place |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

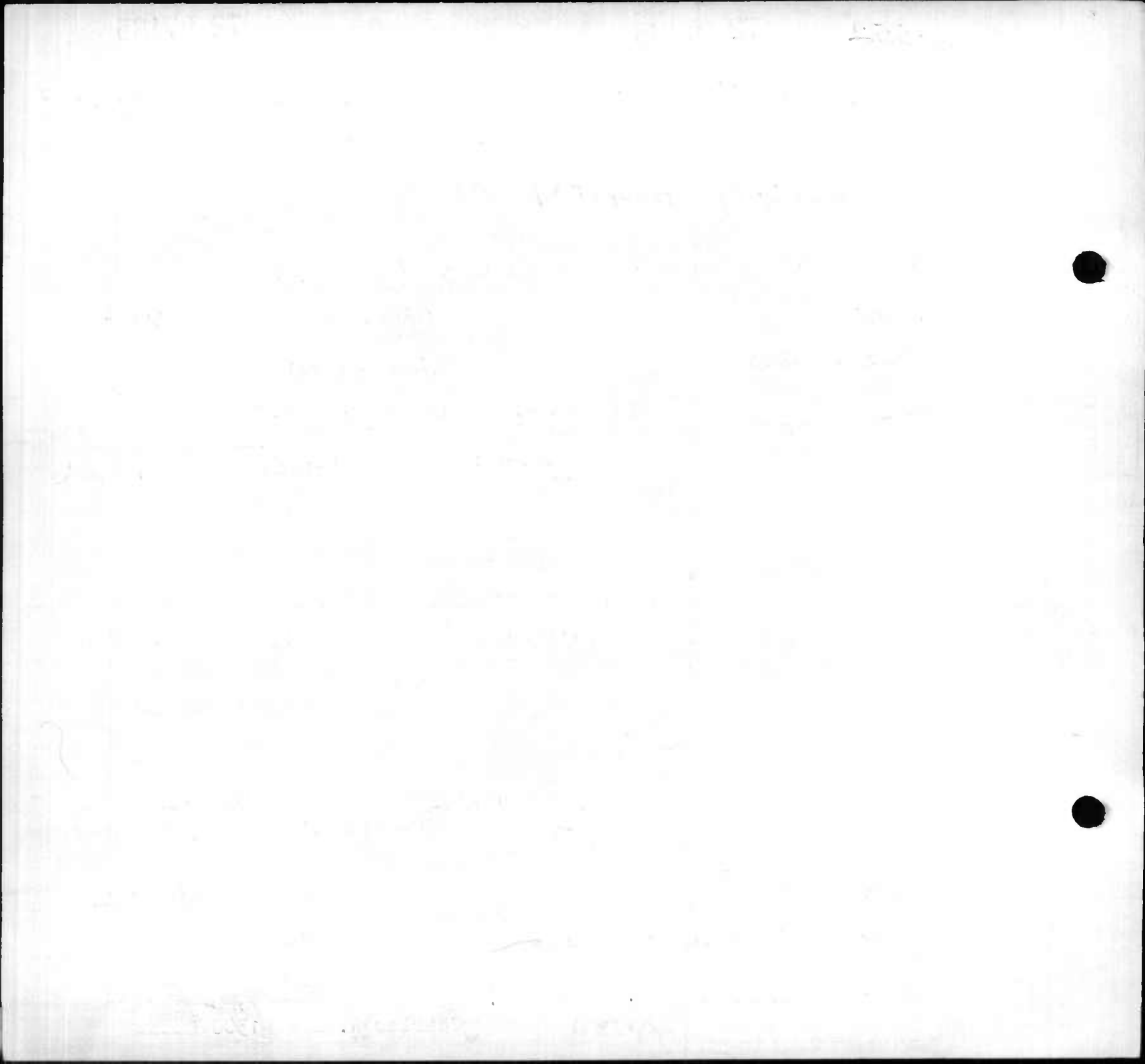
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07134 | | 72 07134 | |
|--|--|--|--|--|--|---|--|
| BIRTH NO. | | | | 72 07134 | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| MOSES R. JONES | | | | 7/25/72 5:35 AM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE | | B. COUNTY | |
| 34 BON SECOURS | | | | MARYLAND | | 21223 2004 | |
| 5. SEX | | | | 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| male | | | | B | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH | |
| Retired Disabled | | | | | | 11/29/11 | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | 9. AGE (In years lost birthday) | |
| 7 | | | | Susie Jones? | | 60 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| Unknown | | | | 212 09 2026 | | Front Street of Chest | |
| 18. CAUSE OF DEATH | | | | 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4/2/71 | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | Insufficiency | |
| (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) | | | | Myocardial infarction | | 90% | |
| 20. ANTECEDENT CAUSES | | | | (B) CHRONIC CARDIOVASCULAR INSUFFICIENCY | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | | | (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 0 | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7 23 1972 to 7 25 1972 that (I) (we) last saw the deceased alive on 7 25 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Whangave | | | | 7 25 72 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| U. Bhargava | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 7/28/72 | | Mt. Auburn Cem. | | Westport, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT | | 25B. NAME OF FUNERAL DIRECTOR | | 25C. FUNERAL DIRECTOR ADDRESS | | | |
| JUL 28 1972 | | Charles A. Rice | | 1300 Eutaw Place | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

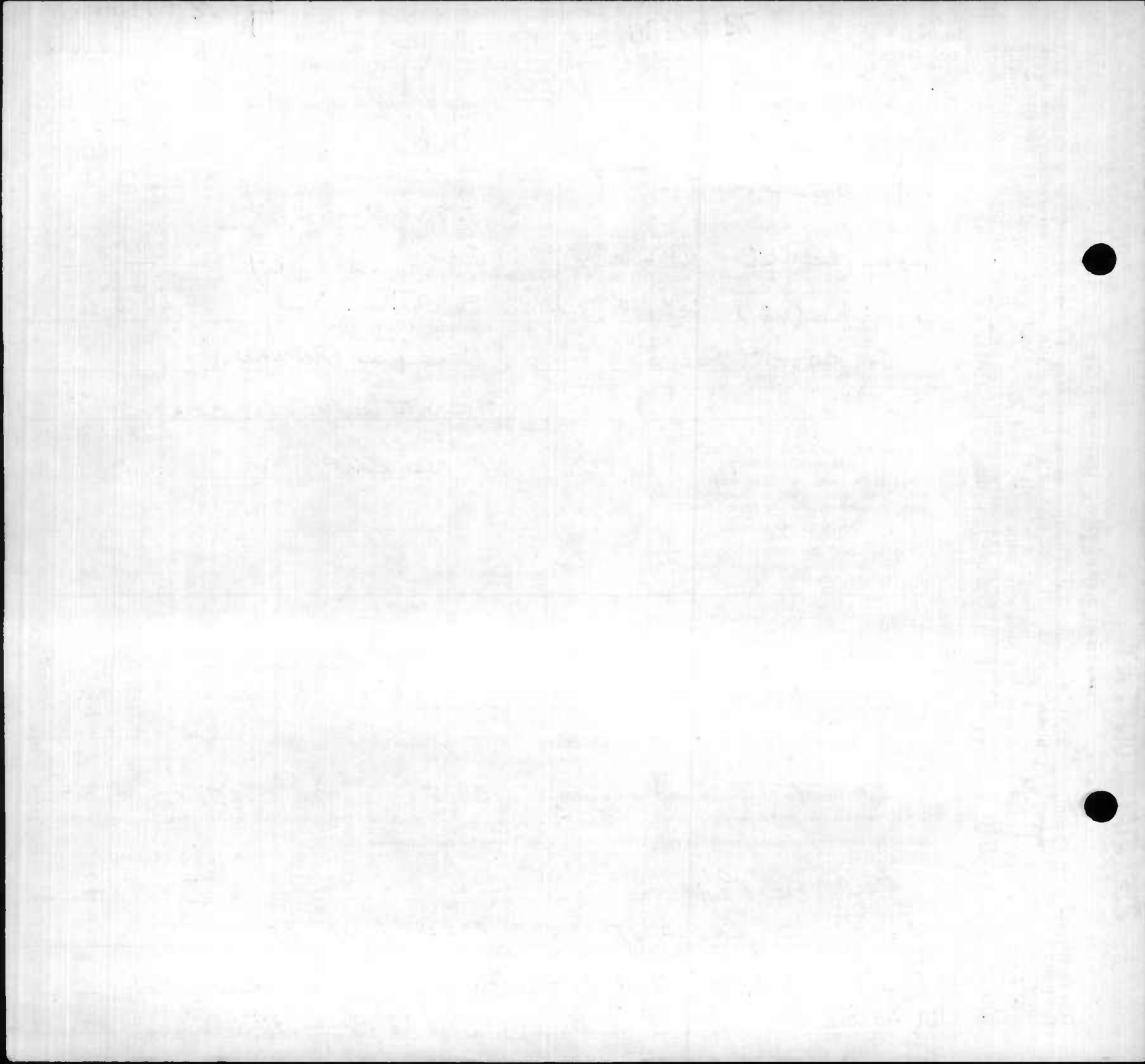
| J-552 | | 72 07135 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07135 | |
|---|---------------------|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | STATE OF MARYLAND-DEME | | | |
| 1. NAME OF DECEASED (Type or Print) <u>George Jennings</u> | | | | 2. DATE AND HOUR OF DEATH <u>7/21/72</u> <u>1:30 P.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University Hospital</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO.</u> C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1003 Peach Street</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12-14-04</u> | 9. AGE (in years last birthday) <u>67</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 13. FATHER'S NAME <u>Emory Jennings</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>218-03-8448</u> | | 17. INFORMANT <u>Hosp. CHART</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>910X17-145.1 RLL EMPYEMA + SEPSIS</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(B) DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(C) DUE TO, OR AS A CONSEQUENCE OF:</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>SQUAMOUS CELL CA OF PALATE</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 mos.</u> | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7/8/72</u> 19 <u>72</u> to <u>7/21/72</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>7/21</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Mark H. Kasowitz</u> | | | | 23B. DATE SIGNED <u>7/21/72</u> | | 23C. PHYSICIAN'S NAME (Type) <u>MARK H. KASOWITZ MD</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 24B. DATE <u>7/26/72</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 28 1972</u> | | | | 25B. NAME OF REGISTRAR <u>Sidney Johnston</u> | | 25C. FUNERAL DIRECTOR <u>Charles A. Rice</u> | |
| 24D. LOCATION <u>Baltimore, Maryland</u> | | | | 24E. ADDRESS <u>1300 Eutaw</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

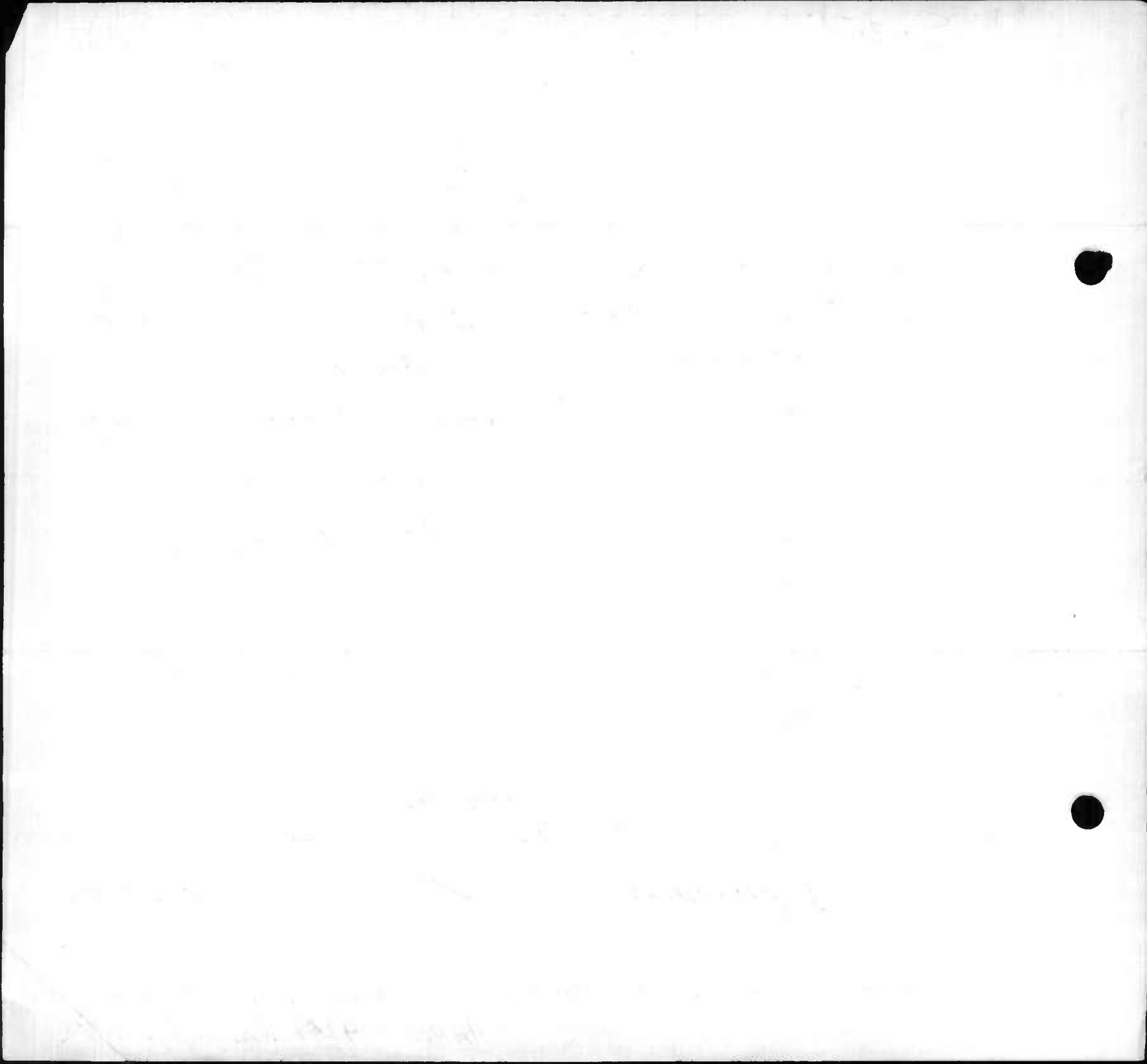
| | | | | | |
|---|---------------------------|---|---|--|---|
| <div style="display: flex; justify-content: space-between;"> (U)-426 72 07136 72 07136 </div> <div style="display: flex; justify-content: space-between;"> BIRTH NO. BALTIMORE CITY HEALTH DEPARTMENT 72 07136 </div> | | CERTIFICATE OF DEATH | | Registered No. <u>STATE OF MARYLAND-DEMH</u> | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Elizabeth Lee Walker</u> | | 2. DATE AND HOUR OF DEATH <u>July 27, 1972 10:30 A.M.</u> | |
| 3. PLACE OF DEATH (If in Baltimore, Maryland) FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>003512 Ellamont Street</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1511</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>3572 Ellamont St</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>colored</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Divorced</u> | 8. DATE OF BIRTH <u>Apr. 2, 1903</u> | 9. AGE (In years last birthday) <u>69</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher (ret.)</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>School Public</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>H. Barnett Lee, Jr.</u> | | 14. MOTHER'S MAIDEN NAME <u>Genevieve Thomas</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>H. Barnett Lee, Jr. 1618 Board St. Baltimore</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <u>RECTAL CARCINOMA</u> DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>?</u> | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <input type="checkbox"/> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5/16</u> 19 <u>72</u> to <u>7/27</u> 19 <u>72</u> . that (I) (we) last saw the deceased alive on <u>7/22</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Alfred R. Rapier</u> | | | | 23B. DATE SIGNED <u>7/27/72</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>ALBERT L. LAFOREST</u> | | | | 23D. ADDRESS <u>822 N. Board St</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>7-31-72</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Not Auburn Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 28 1972</u> | | 25B. NAME OF REGISTRAR <u>Sidney H. [unclear]</u> | | 25C. FUNERAL DIRECTOR <u>John J. [unclear]</u> | |
| | | | | ADDRESS <u>3401 Fairview Ave. 16</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| S-635 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. |
|---|-------------------------|---|--|--|
| 72 07137 | | CERTIFICATE OF DEATH | | 72 07137 |
| BIRTH NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) MARY E. SHERIDAN | | | 2. DATE AND HOUR OF DEATH 7-25-72 | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 2505 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTO. GEN. HOSP | | | C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER 43 | | | F. STREET AND NUMBER 4522 CURTIS AVE | |
| 5. SEX Female | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-23-81 | 9. AGE (In years last birthday) 90 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY SAME | | 11. BIRTHPLACE (State or foreign country) N. H. |
| 13. FATHER'S NAME UNKNOWN | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT DAUGHTER-IN-LAW ADDRESS SAME |
| 18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Aspiration pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CVA w/ Hemiplegia | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION 7/20/72 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 7/20/72 19__ to __ 19__ that (I) (we) last saw the deceased alive on 7/25/72 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE S. Munroe | | | 23B. DATE SIGNED 7/25/72 | |
| 23C. PHYSICIAN'S NAME (Type) SILVINO B. MUNES, M. D. | | | 23D. ADDRESS 5010 RITCHIE HIGHWAY BALTIMORE, MD. 21225 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 7-28-72 | | 24C. NAME of CEMETERY or CREMATORY Glen Haven |
| 24D. LOCATION Ritchie Hwy | | 24E. LOCATION (City, town, or county) (State) Glen Burnie MD | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Adrian Whitton | | 25C. FUNERAL DIRECTOR HAHN ADDRESS 4200 Pennington Ave |



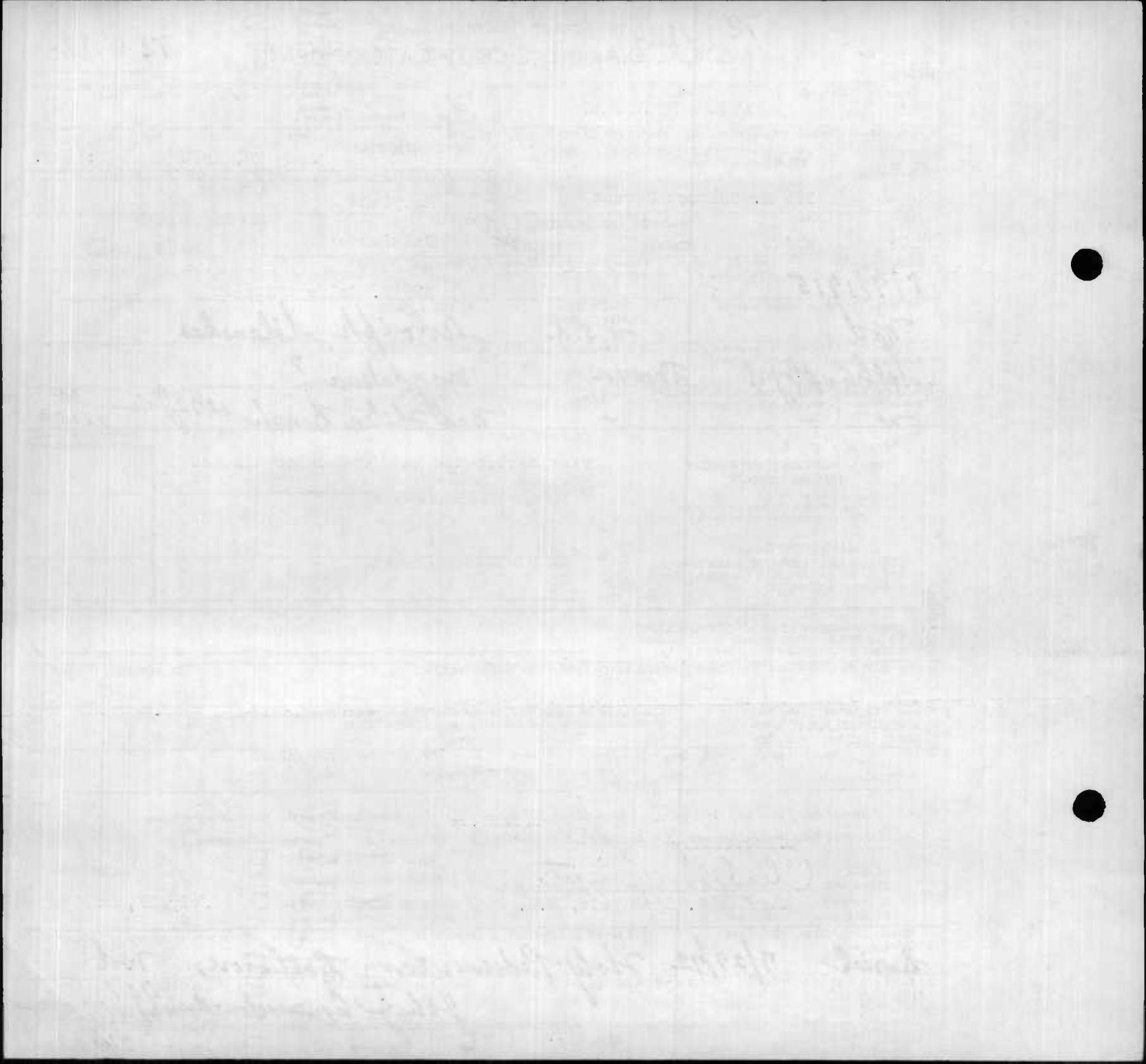
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07138

BIRTH NO.

| | | | | | |
|--|--|---|--|---|---|
| 1. NAME OF DECEASED (Type or Print) | | A. MATTHEW SILANSKAS | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 359 N. Calvert Street | | 3. DATE PRONOUNCED DEAD Month Day Year Hour July 26, 1972 7:18 P.M. | |
| 6. SEX Male | 7. RACE White | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 9. DATE OF BIRTH 8/9/1915 | 10. AGE (In years last birthday) 58 | 11. BIRTHPLACE (State or foreign country) Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | E. STREET AND NUMBER 359 N. Calvert Street | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed | | 14B. KIND OF BUSINESS OR INDUSTRY Barren | | 13. FATHER'S NAME Adolph Silanskas | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. ✓ | | 15. MOTHER'S MAIDEN NAME Magdalena? | |
| 18. INFORMANT Mrs Helen Bench | | ADDRESS 1272 James St. 21223 | | 19. 4/12.4 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 20A. DATE OF OPERATION 7/29/72 | |
| 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) Yes | | 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | | 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 27, 1972 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 7/29/72 | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Con. | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | 25B. NAME OF REGISTRAR Sidney W. Horton | 25C. FUNERAL DIRECTOR John J. Kowarsky | | ADDRESS 991 Hollins St. 21223 | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 72 07139 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07139 | |
|---|--|--|--|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) | | Daniel Hall | | 2. DATE AND HOUR OF DEATH | | 7/23/72 6:50 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | STATE OF MARYLAND - DEATH | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| 90 Century Home, Inc. 102 N. Paca St. Baltimore, Md. 21201 | | 102 N. Paca St. Balto., Md. 402 | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER | | 102 N. Paca St. | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| M | | N | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 1/5/05 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday) | | 11. BIRTHPLACE (State or foreign country) | |
| Retired Railroad | | | | 66 | | Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | | USA | |
| Dan Hall | | Marie Hall | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| Unk | | 244-14-4631 | | 17. INFORMANT | | ADDRESS | |
| | | | | William Hall | | 815 Thayer Ave Silver Spring, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | Cardio-Respiratory Failure | | | | | |
| ANTECEDENT CAUSES | | (A) IMMEDIATE CAUSE | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | DUE TO, OR AS A CONSEQUENCE OF: | | Arteriosclerotic CVD | | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | Gen & Cerebral Dist | | | |
| | | (C) | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | Bilat Amputee | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 0 | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (Approx.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 1 1971 to July 23 1972 that (I) (we) last saw the deceased alive on July 23 1972 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| William Appleford | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| William Appleford | | | | 6615 Reisterstown Rd | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| | | 7/29/72 | | Harmony Memorial Park | | Landover, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JUL 31 1972 | | [Signature] | | [Signature] | | 4804 Ga Ave NW | |

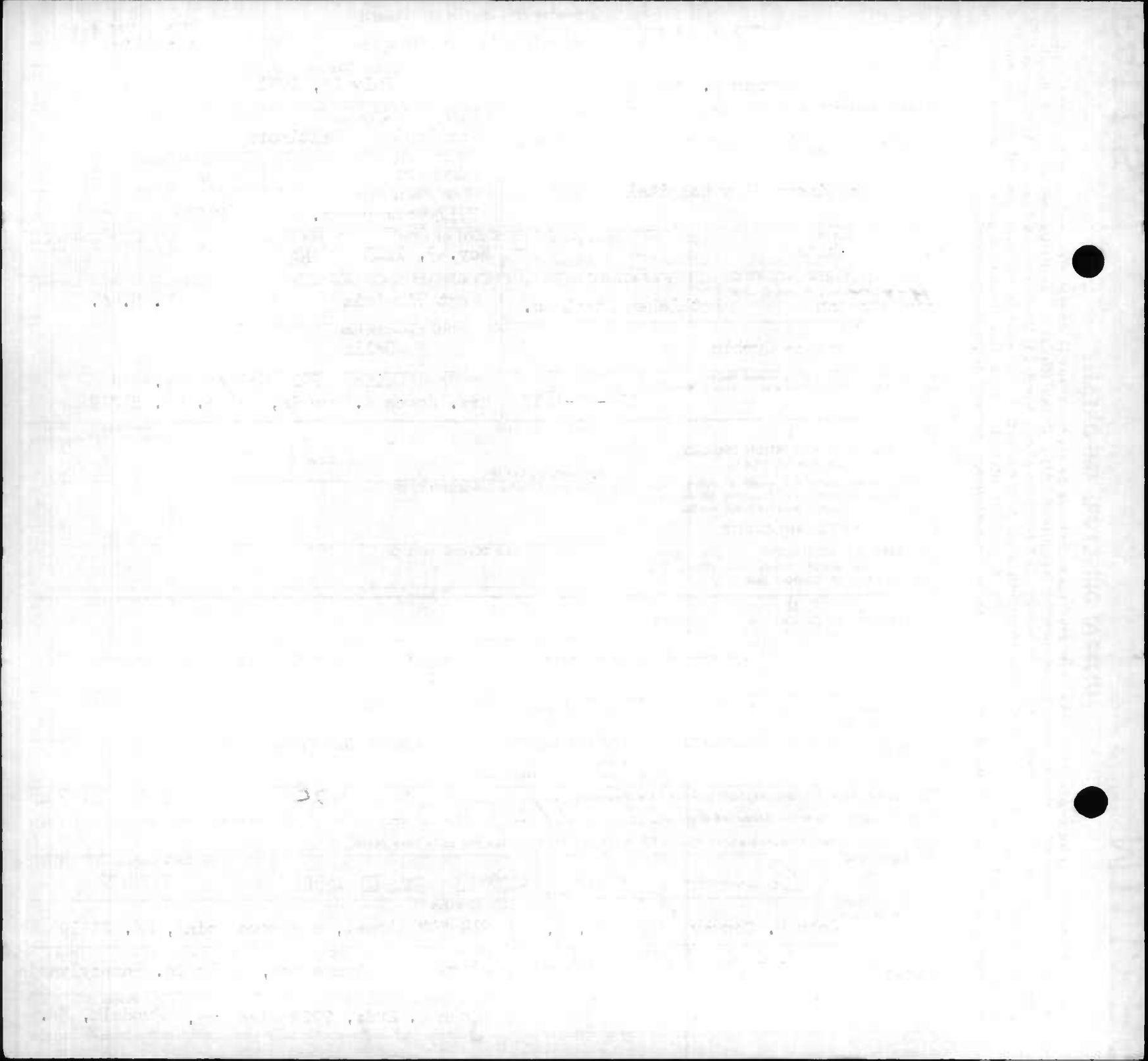
12/1/71

Prev. address another N.H. (Lincoln)

FUNERAL DIRECTOR: IMPORTANT

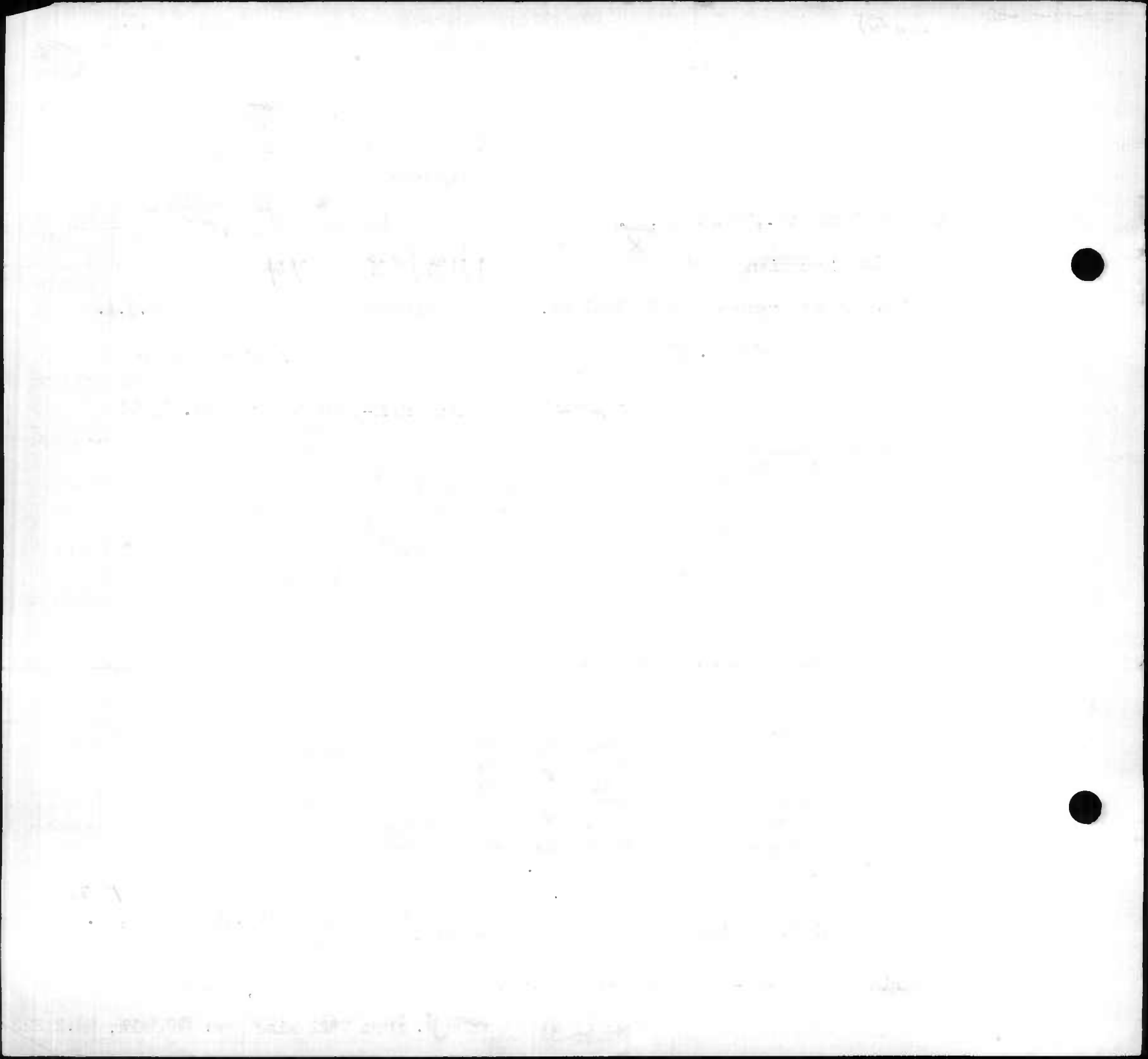
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07140 | |
|--|---------|--|------------------|--|--------------------------------|
| 72 07140 | | | | STATE OF MARYLAND - DDMH | |
| BIRTH NO. 8-615 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Herman A. Durbin | | July 25, 1972 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | | | |
| 31 Baltimore City Hospital | | Maryland Baltimore 5300 | | | |
| | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | Edgemere | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | E. STREET AND NUMBER | | | |
| | | 2911 Delmar Ave. 21219 | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. IF Under 1 Yr. Months Days |
| Male | White | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | Nov. 9, 1923 | 48 | Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Warehouseman | | Bethlehem Steel Co. | | West Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? | | U. S. A. | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| Lawrence Durbin | | Della | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT (Wife) 2911 Delmar Ave. ADDRESS | |
| No | | 235-22-5617 | | Mrs. Joyce E. Durbin, Balto. Md. 21219 | |
| CAUSE OF DEATH | | | | | |
| 18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: myocardial infarction | | | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (C) _____ | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 1 Month 1 Day 1 Year 1 Hour | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 19 58 to 7/25 19 72 that (I) (we) last saw the deceased alive on 7/25 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE John V. Conway, M.D. | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| John V. Conway M. D. | | | | 914 "D" Street, Sparrows Point, Md. 21219 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 7/29/72 | | Good Shepherd Cemetery | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. FUNERAL DIRECTOR ADDRESS | | | |
| Tuckerton, Berks Co. Pennsylvania | | John J. Duda, 7922 Wise Ave. Dundalk, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JUL 31 1972 | | Audrey Johnson | | John J. Duda, 7922 Wise Ave. Dundalk, Md. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| A-450 | | 72 07141 | | BALTIMORE CITY HEALTH DEPARTMENT | | X REG. NO. 72 07141 | |
| BIRTH NO. | | | | STATE OF MARYLAND-DEMR | | | |
| 1. NAME OF DECEASED (Type or Print) John H. Allen | | | | 2. DATE AND HOUR OF DEATH 7/24/1972 10:30 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Balt. City Hospitals | | | | A. STATE Maryland B. COUNTY Baltimore | | | |
| 4940 Eastern Ave., Baltimore, Md. | | | | C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| E. STREET AND NUMBER 34 North Dundalk Avenue | | | | 21222 | | | |
| 5. SEX Male | | 6. RACE Caucasian | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1/13/98 | |
| | | | | 9. AGE (In years lost birthday) 74 | | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Labor Foreman | | | | 10B. KIND OF BUSINESS OR INDUSTRY Beth Steel Co. | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Patrick A. Allen | | | | 14. MOTHER'S MAIDEN NAME Catherine Schuler | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I | | | | 16. SOCIAL SECURITY NO. 213-07-3406 | | 17. INFORMANT ADDRESS Records: BCH-4940 Eastern Ave. 21224 | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE Resp. Failure | | | |
| ANTECEDENT CAUSES | | | | DUE TO, OR AS A CONSEQUENCE OF: Chronic emphysema | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) Congestive heart failure | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF: Chronic Renal Failure | | | |
| | | | | (C) 4 mos | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/19/72 to 7/24/72 that (I) (we) last saw the deceased alive on 7/24/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Matthew Fine | | | | 23B. DATE SIGNED 7/24/1972 | | | |
| 23C. PHYSICIAN'S NAME (Type) Matthew Fine | | | | 23D. ADDRESS 4940 Eastern Ave., Baltimore, Md. Baltimore City Hospitals | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) Burial | | 24B. DATE 7-28-72 | | 24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Sidney J. Duda | | 25C. FUNERAL DIRECTOR John J. Duda | | ADDRESS 7922 Wise Ave. Dundalk, Md. 21222 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-17-72

1 adj

D-362

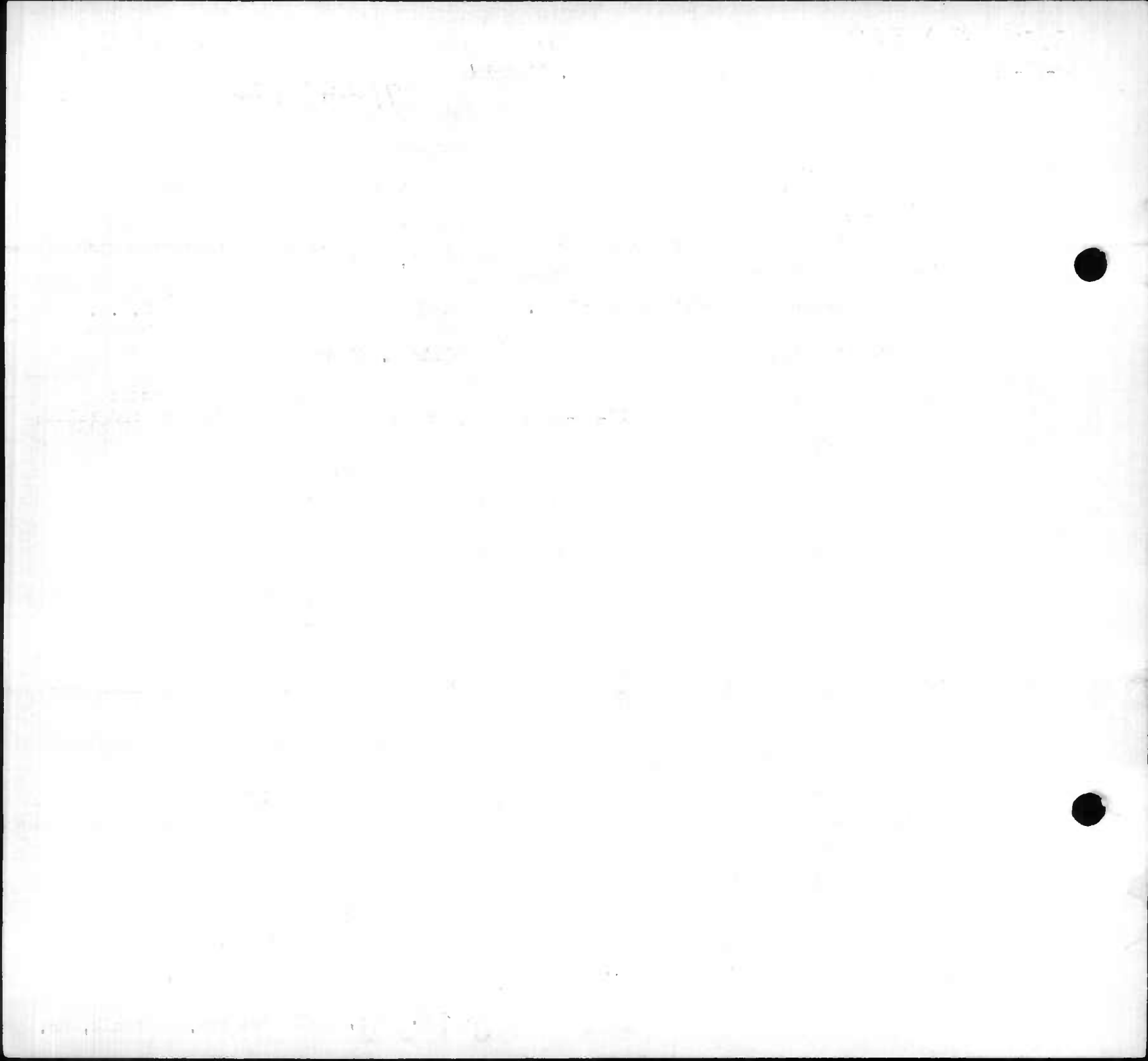
72 07142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 72 07142
STATE OF MARYLAND-DHMH

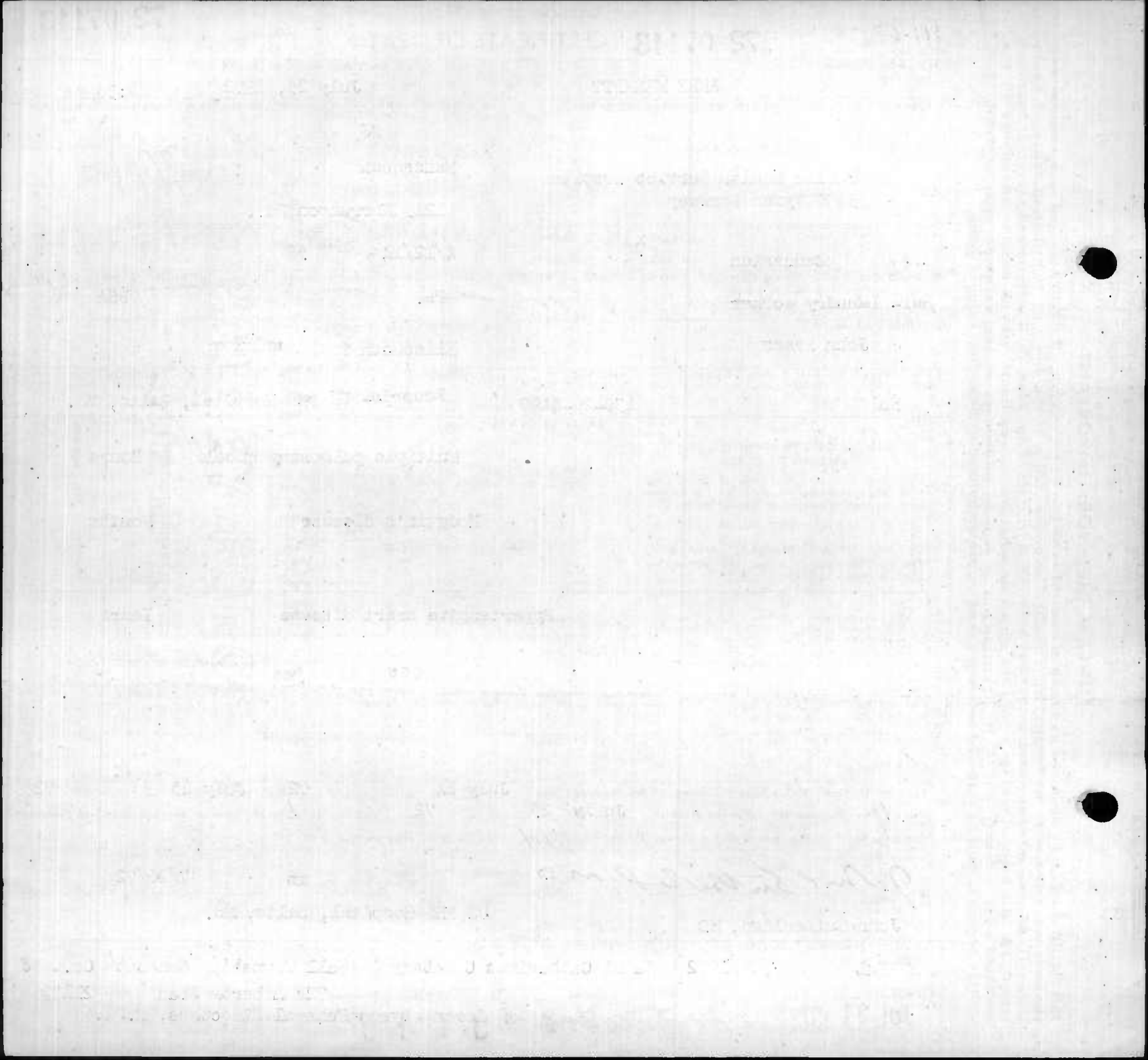
| | | | | | |
|--|-----------------------------|---|---|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>Charles F. Dietrich</i> | | 2. DATE AND HOUR OF DEATH <i>7/24/72 1 30 A</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2605</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>461 Hornel Street 21224</i> | |
| 5. SEX <i>Male</i> | 6. RACE <i>Caucasian</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>March 12, 1919</i> | 9. AGE (In years last birthday) <i>53</i> | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Crane Operator</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Bethlehem Steel Co.</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Francis Dietrich</i> | | 14. MOTHER'S MAIDEN NAME <i>Ollie B. Higgs</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WWII</i> | | 16. SOCIAL SECURITY NO. <i>217-09-1385</i> | | 17. INFORMANT <i>BCH: RECORDS</i> ADDRESS <i>4940 Eastern Avenue Baltimore, Maryland 21224</i> | |
| 18. <i>450X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>cardio-pulmonary</i> DUE TO, OR AS A CONSEQUENCE OF: <i>1? arrest due to poss. pulmonary emboli</i> (B) <i>pulmonary emboli</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | | |
| 19. DATE OF OPERATION <i>20</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>0</i> | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Low back pain - feel rest acute attack of Gout - arthritis</i> | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>(APPROX)</i> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>21E. INJURY OCCURRED</i> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <i>21F. HOW DID INJURY OCCUR?</i> | |
| 22. I certify that (1) (this hospital) attended the deceased from <i>7/17/1972</i> to <i>7/24/1972</i> that (2) (we) last saw the deceased alive on <i>7/24/1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>M. Sankarati</i> | | 23B. DATE SIGNED <i>7/24/72</i> | | 23C. PHYSICIAN'S NAME (Type) <i>MEHDI SANKARATI M.D.</i> | |
| 23D. ADDRESS <i>B.C.V. 4940 Eastern Avenue Baltimore, Maryland 21224</i> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | | |
| 24B. DATE <i>7/28/72</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Oak Lawn Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JUL 31 1972</i> | | 25B. NAME OF REGISTRAR <i>Audrey [illegible]</i> | | 25C. FUNERAL DIRECTOR <i>John J. Duda</i> ADDRESS <i>7922 Wise Ave. Dundalk, Md.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

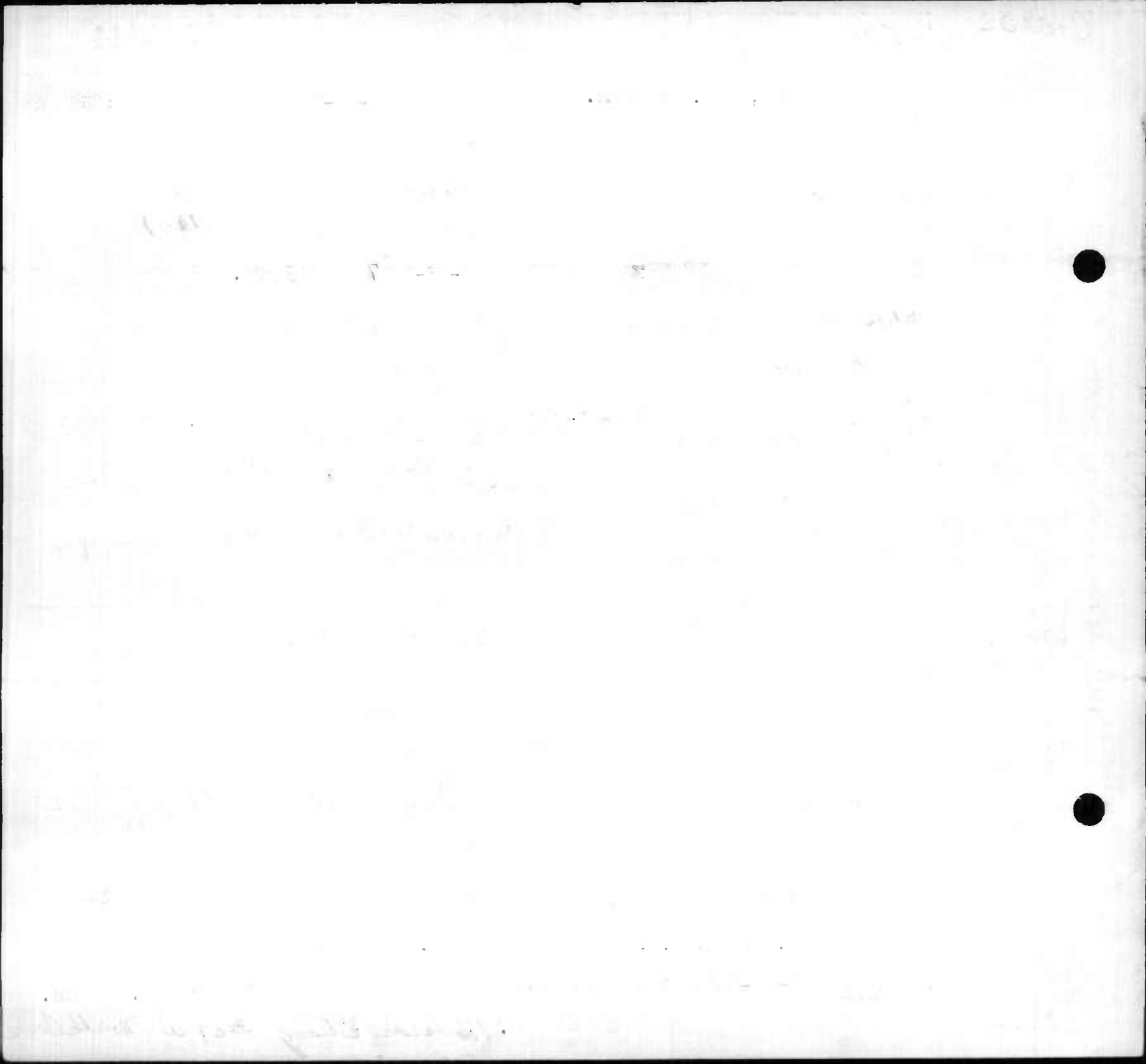
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07143 |
|---|--|--|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. 72 07143 |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | |
| ANNE MERRITT | | July 25, 1972 5:35 A M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | | |
| US Public Health Service Hospital 3100 Wyman Parkway | | NJ | | |
| 5. SEX F | | 6. RACE Caucasian | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |
| 8. DATE OF BIRTH 4/12/14 | | 9. AGE (In years last birthday) 58 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| Hwf- Laundry worker | | 11. BIRTHPLACE (State or foreign country) Pa. | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME John Ivans | | 14. MOTHER'S MAIDEN NAME Elizabeth ? unknown | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 138-20-4190 | | 17. INFORMANT ADDRESS |
| | | Records- US PHS Hospital, Balto, Md. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | Multiple pulmonary emboli | | Hours |
| ANTECEDENT CAUSES | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | Hodgkin's disease | | Months |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | Hypertensive heart disease | | Years |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from July 14 19 72 to July 25 19 72, that (I) (we) last saw the deceased alive on July 25 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE John C. Sutherland, M.D. | | | | 23B. DATE SIGNED 7/26/72 |
| 23C. PHYSICIAN'S NAME (Type) John Sutherland, MD | | 23D. ADDRESS US PHS Hospital, Balto, Md. | | |
| 24A. BURIAL CRIMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 7/29/1972 | | 24C. NAME OF CEMETERY or CREMATORY Saint Catharines Cemetery |
| 24D. LOCATION (City, town, or county) (State) Wall Township Monmouth Co., NJ | | 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | |
| 25B. NAME OF REGISTRAR Sidney H. ... | | 25C. FUNERAL DIRECTOR 8728 Liberty Road ADDRESS 21133 Loring Byers Funeral Directors, P. A. | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

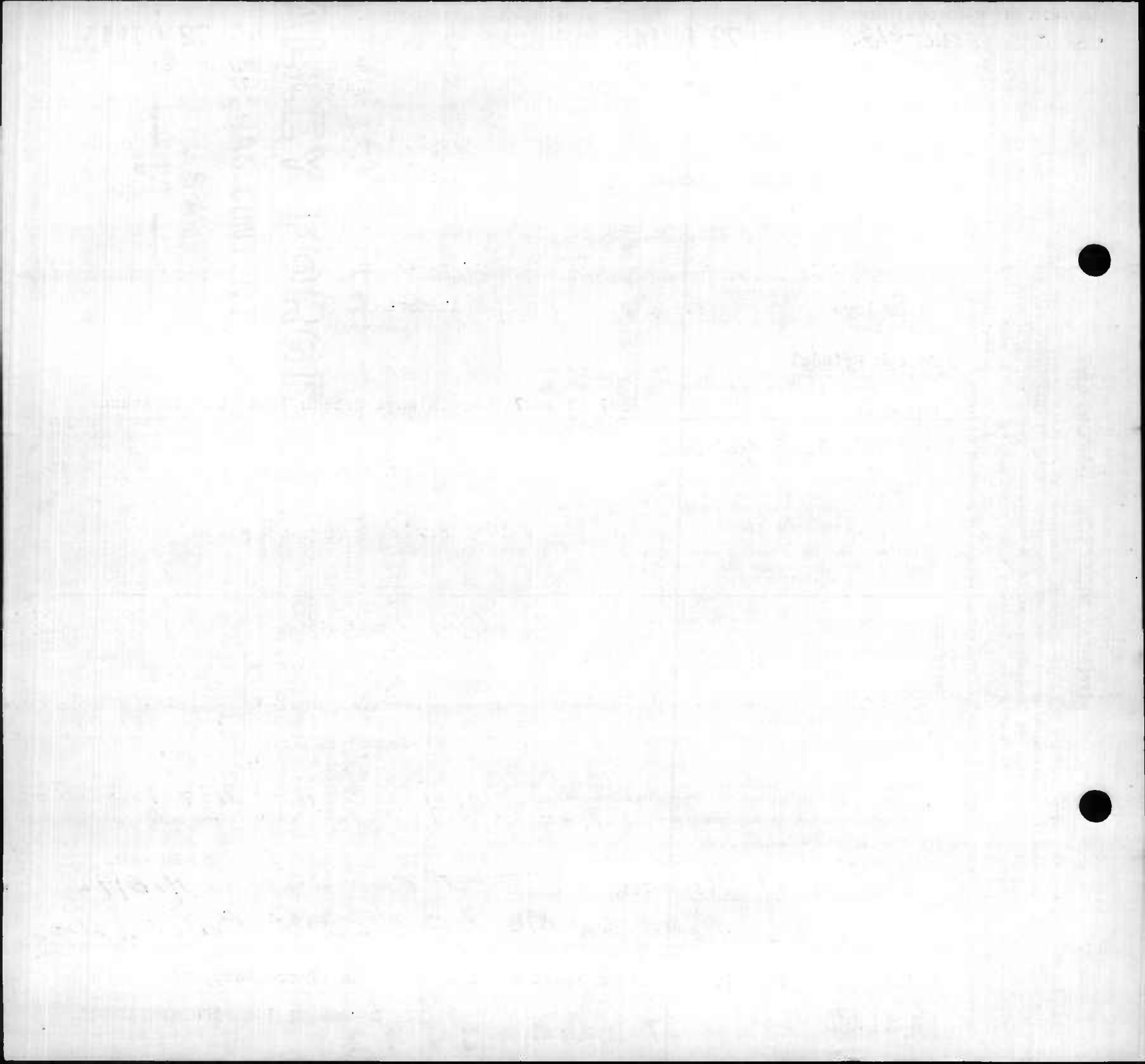
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07144 | |
|--|---------------------|---|---|--|---|
| C-522 | | | | 72 07144 | |
| BIRTH NO. | | | | STATE OF MARYLAND-DEPT | |
| 1. NAME OF DECEASED (Type or Print) COMEGYS, MRS. GRACE M. | | | 2. DATE AND HOUR OF DEATH 7-26-72 9:15 AM. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) KESWICK HOME | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER ADDRESS UNKNOWN | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-23-1897 | 9. AGE (In years last birthday) 75 yrs. | 10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY NONE | | 11. BIRTHPLACE (State or foreign country) WINCHESTER, VIRGINIA | |
| 13. FATHER'S NAME JOSEPH SNAPP | | | 14. MOTHER'S MAIDEN NAME CATHERINE BLANCHFIELD | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 179-03-0486 | | 17. INFORMANT KESWICK RECORDS ADDRESS 700 W. 40th Street | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 441.1 + 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Ruptured Thoracic aortic aneurysm | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 42 hr | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic CVD (B) DUE TO, OR AS A CONSEQUENCE OF: may yrs (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes Mellitus | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 25 Jan 1961 to 26 Jul 1972 and that (I) (we) lost saw the deceased alive on 26 Jul 1972 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Harold P. Biehl | | | 23B. DATE SIGNED 26 Jul 72 | | |
| 23C. PHYSICIAN'S NAME (Type) HAROLD P. BIEHL, M.D. | | | 23D. ADDRESS 700 W. 40th Street | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-29-1972 | | 24C. NAME of CEMETERY or CREMATORY Good Shepherd | |
| 24D. LOCATION Howard Co. | | 24E. (City, town, or county) | | 24F. (State) Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Dudley W. Strong | | 25C. FUNERAL DIRECTOR Howard Strong ADDRESS 307 W. North Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07145 | |
|--|---------------------|--|--------------------------------------|--|---|
| 72 07145 CERTIFICATE OF DEATH | | | | STATE OF MARYLAND - DEPT | |
| U-612 BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) ALBERT FRIEDEL URBACH | | 2. DATE AND HOUR OF DEATH July 25 1972 | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 1106 Dundalk Avenue | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN Baltimore E. STREET AND NUMBER 1106 Dundalk Avenue | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-30-1910 | 9. AGE (In years last birthday) 62 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RR. Employee | | 10B. KIND OF BUSINESS OR INDUSTRY P. B R RR | | 11. BIRTHPLACE (State or foreign country) Baltimore | |
| 13. FATHER'S NAME Joseph Friedel | | 14. MOTHER'S MAIDEN NAME ? | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 837 12 1827 | | 17. INFORMANT Mrs. Albert Urbach 1106 Dundalk Avenue | |
| 18. 157.9 4 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pancreatic Carcinoma | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 months | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes Mellitus | | (B) DUE TO, OR AS A CONSEQUENCE OF: > 9 months | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | 21. DATE OF OPERATION 10/21 | | 22. CONDITION FOR WHICH OPERATION WAS PERFORMED Diabetes Mellitus | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/21 19 71 to 7/24 19 72 , that (I) (we) last saw the deceased alive on 7/24 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Samuel Morrison | | | | 23B. DATE SIGNED 7/26/72 | |
| 23C. PHYSICIAN'S NAME (Type) SAMUEL MORRISON MD | | 23D. ADDRESS 11 E. Chase St Balto Md 21202 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-28-72 | | 24C. NAME OF CEMETERY or CREMATORY Sacred Heart of Jesus | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | | |
| 25B. NAME OF REGISTRAR Walter Dabrowski | | 25C. FUNERAL DIRECTOR WALTER DABROWSKI 1005 DUNDALK AVENUE | | | |
| 25D. ADDRESS 1005 DUNDALK AVENUE | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07146 | |
|---|-------------------------|---|--|--|---|
| M-324 72 07146 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) MITCHELL, PETER | | 2. DATE AND HOUR OF DEATH July 27, 1972 1:00 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2101 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 805 MANGOLD STREET | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-5-1907 | 9. AGE (In years last birthday) 64 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY Truck Driver | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Peter Mitchell | | 14. MOTHER'S MAIDEN NAME Rose Mica | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. --- | | 17. INFORMANT Elizabeth Mitchell ADDRESS 805 Mangold Street Baltimore, Maryland 21230 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 162.1 I CONGESTIVE HEART FAILURE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PULMONARY EDEMA WITH MASSIVE PLEURAL EFFUSION (B) DUE TO, OR AS A CONSEQUENCE OF: CANCER OF THE LUNG (C) 2 DAYS | | | CAUSE OF DEATH CONGESTIVE HEART FAILURE 2 DAYS | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from July 24 1972 to July 27 1972, that (I) (X) lost saw the deceased alive on July 27 1972 and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE July Jostoff, M.D. | | | | 23B. DATE SIGNED July 27, 1972 | |
| 23C. PHYSICIAN'S NAME (Type) JULI G. JOSHEFF, M.D. | | | | 23D. ADDRESS 2085 Woodbourne Ave, Baltimore, Md. 21234 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-31-72 | | 24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | | |
| 25B. NAME OF REGISTRAR July 31 1972 | | 25C. FUNERAL DIRECTOR McCully Funeral Home Balto., Md. 21230 | | | |

15-11-10

(12)

Home Film

Home Film

(Additional, original)

7-11-10 (Color, all (original)

Color

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07147 | |
|--|------------------|--|---|--|---|
| 7-615 72 07147 | | | | STATE OF MARYLAND-DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) T. Mary Fairbanks | | 2. DATE AND HOUR OF DEATH 7-27-72 3:40 p.m. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. BALTO 5300 B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2024 N. Rolling Road | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 4-24-35 | 9. AGE (In years last birthday) 37 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker - Secretary | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James Turner | | 14. MOTHER'S MAIDEN NAME Agnes Hauf | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS Agnes Hauf-2024 N. Rolling Rd. | | |
| 18. 564.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Constrictive heart failure (B) DUE TO, OR AS A CONSEQUENCE OF: Islet, pulm. ecthema (C) Multiple rib fractures Emaciation | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) 1 Month 1 Day (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 19 to 19 that (1) (we) last saw the deceased alive on 7/27 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE John E. Seibel, MD | | | | 23B. DATE SIGNED 7/28/72 | |
| 23C. PHYSICIAN'S NAME (Type) John E. Seibel, MD | | 23D. ADDRESS Mercy Hosp | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-31-72 | | 24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | |
| 24D. LOCATION Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | | |
| 25B. NAME OF REGISTRAR Sidney H. Hight | | 25C. FUNERAL DIRECTOR ADDRESS Armstrong Funeral Chapel-4600 Liberty Hgts | | | |

SECRET -

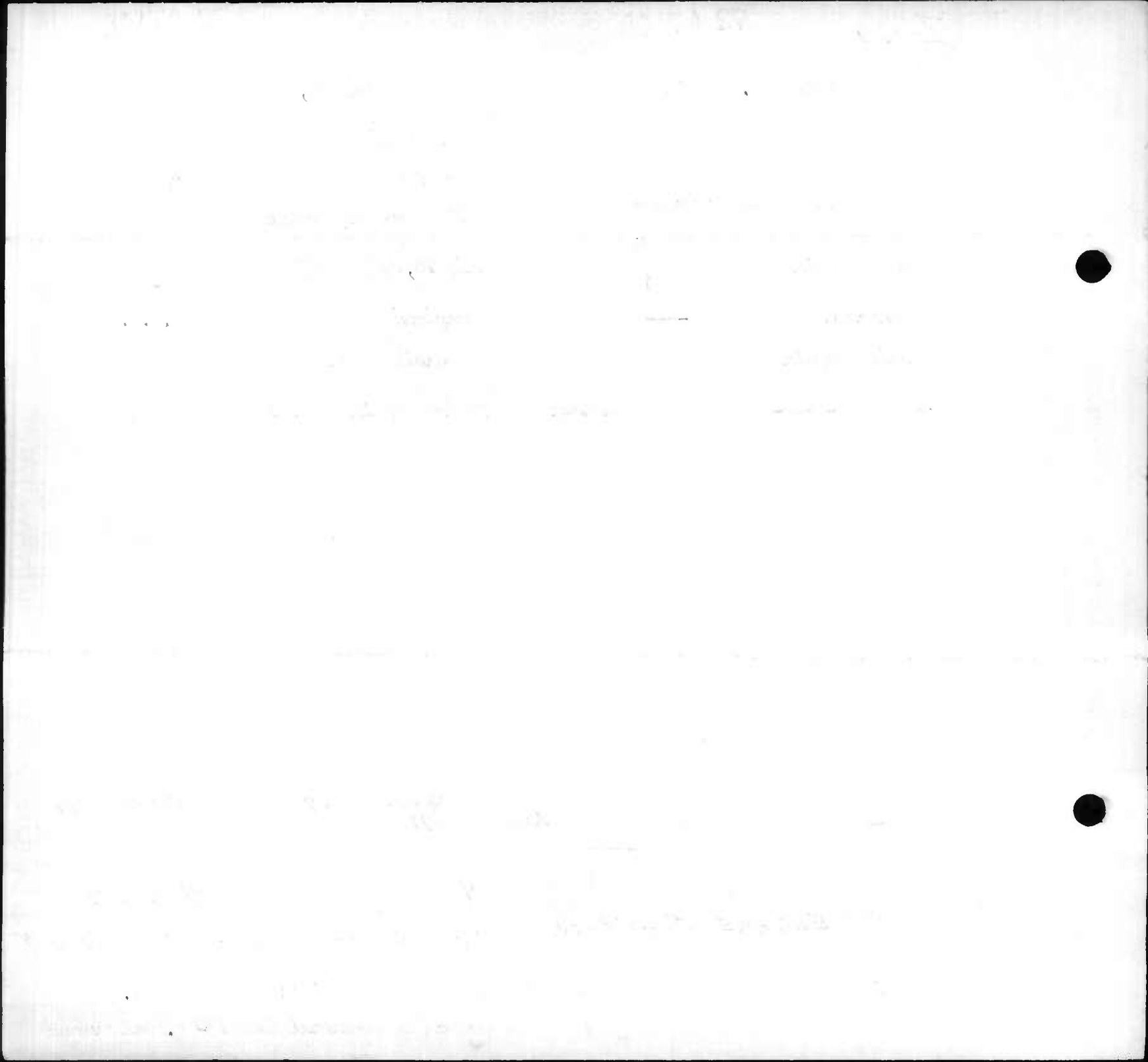
... office ...

11-17-64 1-2-65 1-2-65 1-2-65

11-17-64 1-2-65 1-2-65 1-2-65

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

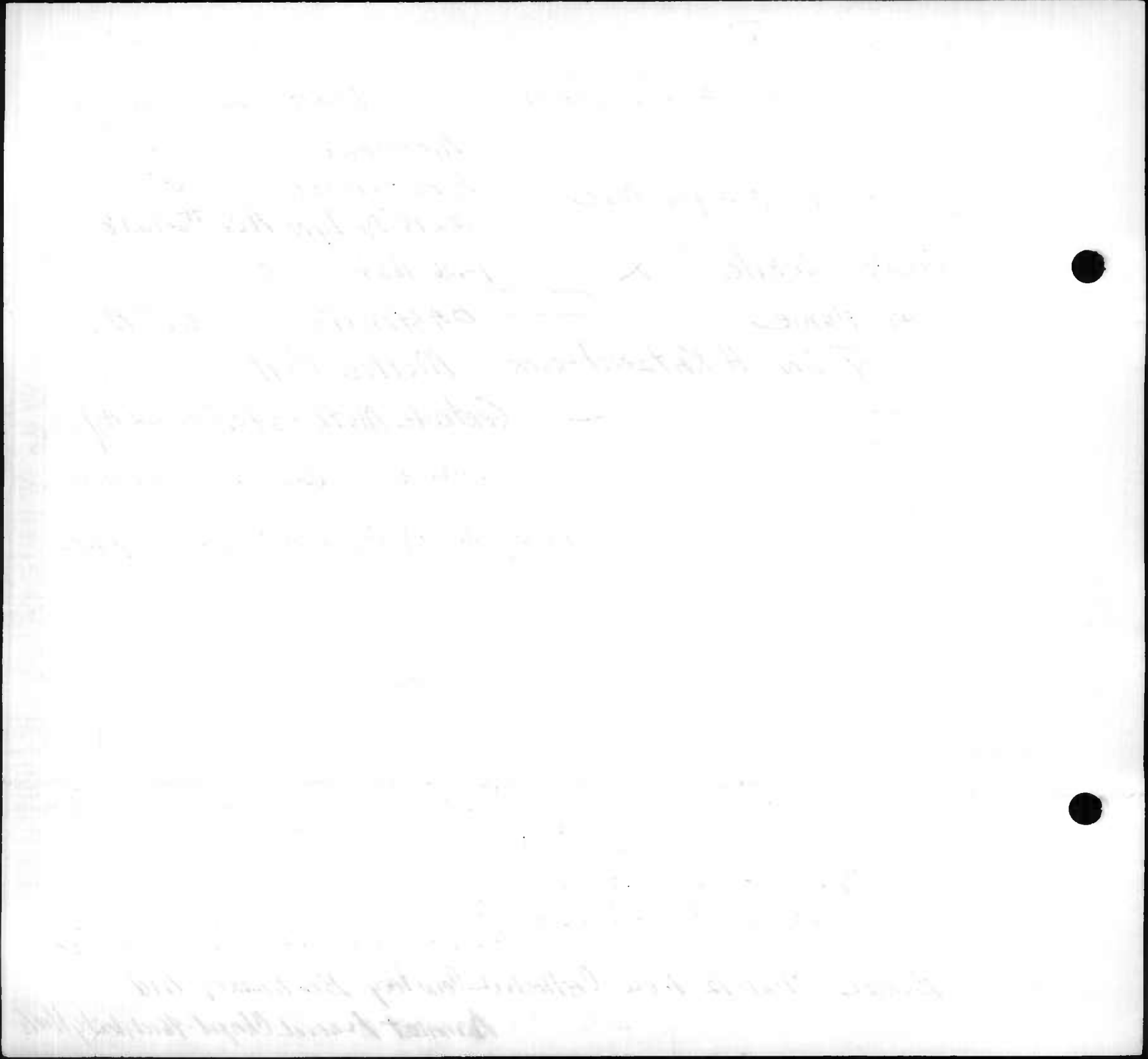
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|--|-------------------------|---|---|--|--|---|---|
| Z-160 | | 72 07148 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07148 | |
| BIRTH NO. | | | | REG. NO. | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Henry C. Zephir</i> | | | | 2. DATE AND HOUR OF DEATH <i>July 25, 1972</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>00 1408 Battery Avenue</i> | | | | A. STATE <i>Maryland</i> B. COUNTY <i>2403</i> | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN <i>Baltimore</i> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER <i>1408 Battery Avenue</i> | | | |
| 5. SEX <i>Male</i> | 6. RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>July 10, 1905</i> | 9. AGE (In years last birthday) <i>67</i> | 10. Under 1 Yr. Months: Days: Hours: Min. | 11. Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>unknown</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> |
| 13. FATHER'S NAME <i>Charles Zephir</i> | | | 14. MOTHER'S MAIDEN NAME <i>Donothy Zang</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | | 16. SOCIAL SECURITY NO. <i>unknown</i> | | 17. INFORMANT <i>Thelma Zephir ??</i> | | ADDRESS |
| 18. CAUSE OF DEATH | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>myocardial infarction</i> | | | |
| | | | | (B) <i>atherosclerotic hypercholesterolemia</i> DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (C) _____ | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Jan 1967</i> to <i>Dec. 1971</i> that (I) (we) last saw the deceased alive on <i>Dec 19 1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Eugene Schnitzer</i> | | | | 23B. DATE SIGNED <i>7-27-72</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>EUGENE SCHNITZER MD</i> | | | | 23D. ADDRESS <i>3904 S. HANOVER ST. Balto. Md. 21225</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>7/29/72</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Holy Cross Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JUL 31 1972</i> | | 25B. NAME OF REGISTRAR <i>Andrew H. ...</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Mc Cubly Funeral Home 130 E. Fort Avenue</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | | | |
|---|-------------------------|---|--|---|--|---|--|---|--|
| J-520 | | 72 07149 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | REG. NO. 72 07149 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>ANNA B. Jean</u> | | | | 2. DATE AND HOUR OF DEATH <u>7-27-72</u> <u>1:00 P.</u> M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 2216 Roslyn Ave</u> | | | | | | A. STATE <u>MARYLAND</u> | | B. COUNTY <u>1548</u> | |
| | | | | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | | | E. STREET AND NUMBER <u>2216 Roslyn Ave #21216</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1-26-1886</u> | 9. AGE (In years last birthday) <u>86</u> | 10. If Under 1 Yr. Months: Days: Hours: Min. | | 11. If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John H Katzenberger</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mollie Bell</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u> | | | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT <u>Gertrude Muth - 34016 GREENWAY</u> | | ADDRESS | |
| 18. <u>410.9</u> I CAUSE OF DEATH | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE <u>CORONARY OCCLUSION</u> DUE TO, OR AS A CONSEQUENCE OF: | | | | <u>10 min.</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) <u>Coronary arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF: | | | | <u>5 years</u> | |
| (C) _____ | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Aug 18, 1970</u> to <u>July 24, 1972</u> that (I) (we) last saw the deceased alive on <u>July 17, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Abraham B. Hurwitz MD</u> | | | | | | 23B. DATE SIGNED | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>ABRAHAM B. HURWITZ MD</u> | | | | | | 23D. ADDRESS <u>7501 LIBERTY ROAD BALTIMORE MD</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>7-27-72</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery Baltimore, Md</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 31 1972</u> | | | | 25B. NAME OF REGISTRAR <u>—</u> | | 25C. FUNERAL DIRECTOR <u>—</u> | | ADDRESS <u>—</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|--|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07150 | |
| S-536 72 07150 | | CERTIFICATE OF DEATH | |
| BIRTH NO. 72 07150 | | STATE OF MARYLAND-DEM | |
| 1. NAME OF DECEASED (Type or Print) Supper, Margaret Elizabeth | | 2. DATE AND HOUR OF DEATH 7-26-72 2:30 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD South Baltimore Gen. Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 1803 | |
| FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore Gen. Hospital | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2/1/1902 9. AGE (In years last birthday) 70 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Lady | | 11. BIRTHPLACE (State or foreign country) MD | |
| 10B. KIND OF BUSINESS OR INDUSTRY Theatre | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. ✓ | |
| 17. INFORMANT Mrs. Lena Wade | | ADDRESS 819 W. Lombard St. | |
| 18. 180X I | | CAUSE OF DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Renal Failure | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) CA of Cervix stage III or IV DUE TO, OR AS A CONSEQUENCE OF: | |
| (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/30/72 19 to 7/26 1972, that (I) (we) last saw the deceased alive on 7/26/72 2:30 PM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Cesar M. Cortez M.D. | | 23B. DATE SIGNED 7/26/72 | |
| 23C. PHYSICIAN'S NAME (Type) So. Balt. Gen. Hosp. | | 23D. ADDRESS So. Balt. Gen. Hosp. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/31/72 | |
| 24C. NAME OF CEMETERY OR CREMATORY Landon Park Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Sidney J. ... | |
| 25C. FUNERAL DIRECTOR John J. Gowan & Son Inc. | | ADDRESS 21223 | |

Southwestern Gen Hospital

x

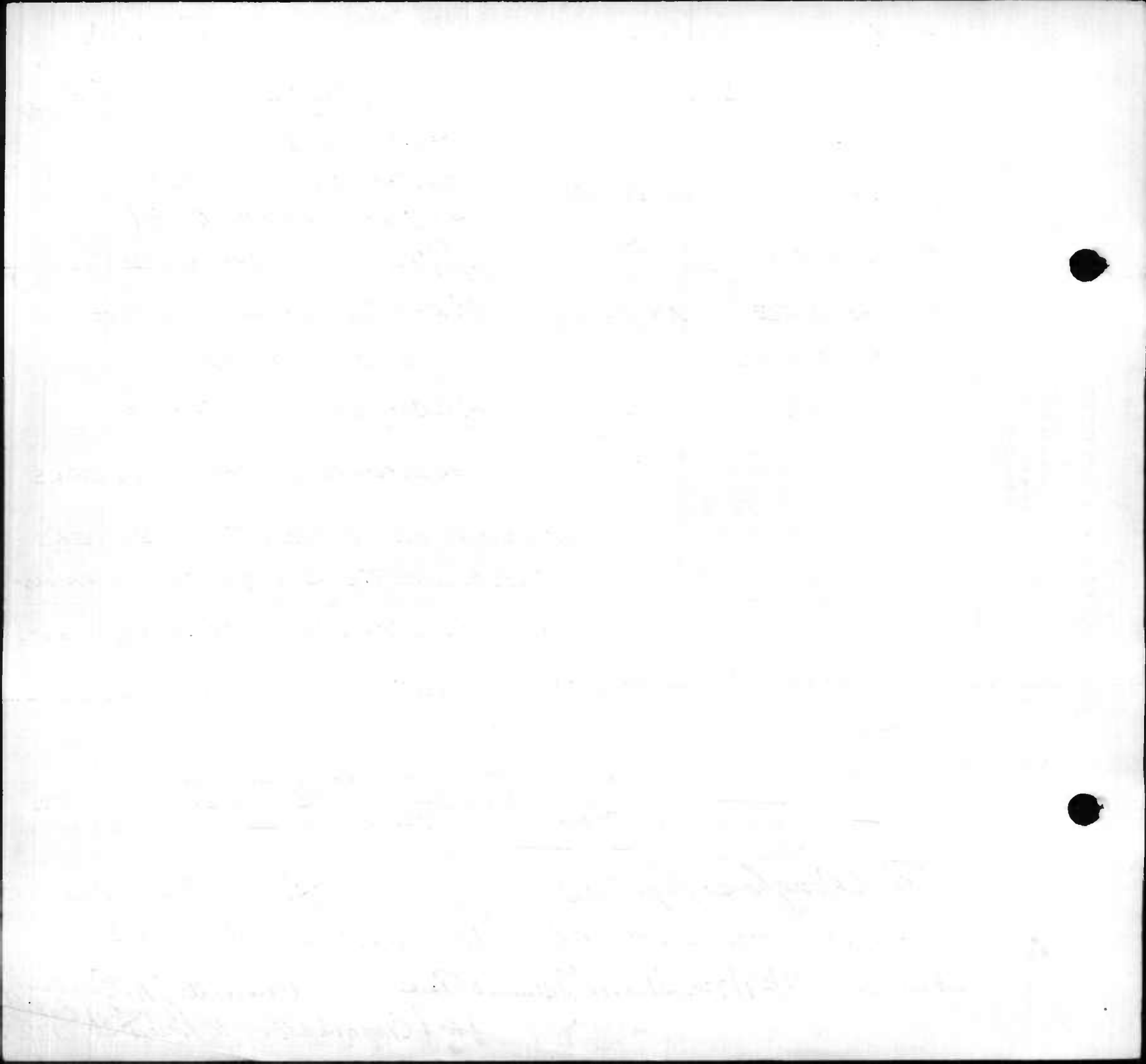
Dr. J. L. Smith

11112 Southwestern Gen Hospital
Phoenix, Arizona

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07151 | | REG. NO. 72 07151 | |
|---|-------------------------|---|-----------------------------------|---|--|---|--|
| BIRTH NO. 4-430 | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) DOROTHY L. HOLT | | | | 2. DATE AND HOUR OF DEATH 7/26/72 215 P | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD UNIVERSITY HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1803 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL | | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 897 W. Lombard St. | | | |
| 5. SEX FEMALE | 6. RACE CAUC. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/1/12 | | 9. AGE (in years last birthday) 60 | 10. Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) NORTH CAROLINA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME UNKNOWN | | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT HUSBAND | | ADDRESS SAME | |
| 18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH | | | | A. IMMEDIATE CAUSE CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | B. MYOCARDIAL INFARCT DUE TO, OR AS A CONSEQUENCE OF: | | 2 WEEKS | |
| | | | | C. ATHEROSCLEROTIC C. V. DISEASE | | UNKNOWN | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CEREBRAL VASCULAR THROMBOSIS 2 WEEKS | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/1/72 19 72 to 7/26 19 72 that (I) (we) lost saw the deceased alive on 7/26 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Paul Douglas Light M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 7/26/72 | |
| 23C. PHYSICIAN'S NAME (Type) PAUL DOUGLAS LIGHT M.D. | | | | 23D. ADDRESS UNIVERSITY HOSPITAL | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) burial | | 24B. DATE 7/29/72 | | 24C. NAME of CEMETERY or CREMATORY Sharon Memorial Park | | 24D. LOCATION (City, town, or county) (State) Charlotte, N. Carolina | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Shirley Whitton | | 25C. FUNERAL DIRECTOR John J. Conroy & Co. 901 N. Hollis St. Balt. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07152 | |
|---|---------------------|--|-----------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. 72 07152 | |
| BIRTH NO. <u>W-460</u> | | 72 07152 | | STATE OF MARYLAND-DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>Richard, Waller</u> | | 2. DATE AND HOUR OF DEATH <u>7-24-72</u> <u>10 45</u> <u>A</u> M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> & COUNTY <u>1701</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Md. Gen. Hosp.</u> | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER <u>W Franklin 501</u> | | | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-4-91</u> | 9. AGE (In years last birthday) <u>81</u> | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Artist</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | |
| 13. FATHER'S NAME <u>Robert Lee Waller</u> | | 14. MOTHER'S MAIDEN NAME <u>Edith Waller</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWII</u> | | 16. SOCIAL SECURITY NO. <u>578-09-9140</u> | | 17. INFORMANT <u>University House 501 Franklin</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, but heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last | | 19. CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>sub-deral and sub-arachnoid haemorrhage</u> (B) <u>Arteriosclerotic C.V.D.</u> (C) <u>—</u> | | | |
| 20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION <u>7-23-72</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u> | | 20A. AUTOPSY (Yes or No) <u>Yes</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u> | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/> * | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Residence</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>501 W. Franklin 17-01</u> | |
| 21D. TIME OF INJURY (APPROX.) <u>7-23-72 12pm</u> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <u>"Fell face down in bathroom"</u> | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7-23</u> 19 <u>72</u> to <u>7-24</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>7-24</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Arnold G. Alexander M.D.</u> | | 23B. DATE SIGNED <u>7-24-72</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Arnold G. Alexander M.D.</u> | | 23D. ADDRESS <u>827 Linden Ave Balt. Md.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>7-26-72</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>GARDENS of FAITH</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 31 1972</u> | | 25B. NAME OF REGISTRAR <u>Andrew Watson</u> | | 25C. FUNERAL DIRECTOR <u>Wm. Cook - Brooks, Watson, Inc</u> | |
| 25D. ADDRESS <u>Towson, Md</u> | | | | | |

9-5-1972 - Letter from Maryland General Hospital, Balto., Md. - Medical Records Director,
Rachel F. Joven - correction of marital status, changed to MARRIED instead
of WIDOWER. HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|------------------|--|------------------------------|---|--|--|--|
| G-630 | | 72 07153 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07153 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) | | STATE OF MARYLAND-DEME | | | | | |
| ElmERT Gayhardt | | 2. DATE AND HOUR OF DEATH 7/28/72 1:20 A | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital Belvedere & Greenspring Avenues Baltimore, Maryland-21233 | | Maryland Baltimore 5300 | | | | | |
| IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| E. STREET AND NUMBER 1169 Granville Rd. | | | | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/23/96 | 9. AGE (In years last birthday) 75 | 10. Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Tavern Owner | | 10B. KIND OF BUSINESS OR INDUSTRY Gayhardts Tavern | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Late Joseph Gayhardt | | 14. MOTHER'S MAIDEN NAME Late Anna Imhoff | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW 1 | | 16. SOCIAL SECURITY NO. 213-10-6027A | | 17. INFORMANT ADDRESS Mrs. Myrtle Gayhardt, 1169 Granville Road | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH Metastasis (A) IMMEDIATE CAUSE Rancer of the Breast DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 7/21/72 to 7/28/72 that (1) (we) last saw the deceased alive on 7/28/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Robert Krooprick, M.D. | | 23B. DATE SIGNED 7/28/72 | | | | 23C. PHYSICIAN'S NAME (Type) Robert Krooprick, M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/31/72 | | 24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D. BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Witzke | | 25C. FUNERAL DIRECTOR 1630 Edmondson Avenue | | ADDRESS 21228 | |

Witzke, 1630 Edmondson Avenue 21228
 Baltimore, Maryland
 Lorraine Park Cemetery
 7/31/72
 Burial

Robert Kroopnick, M. D.

Yes
 WW 1
 213-10-6027A
 Mrs. Myrtle Gayhardt, 1169 Granville Road
 Late Anna Imhoff
 Late Joseph Gayhardt
 Gayhardt's Tavern
 Maryland
 USA

E/m 68

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07154 | |
|---|----------------------|--|------------------------------|---|--|
| 7-642 72 07154 | | | | STATE OF MARYLAND-DMH | |
| BIRTH NO. | | 1 | | | |
| 1. NAME OF DECEASED (Type or Print) | | FROEHLICH, GEORGE LLEWELLYN | | 2. DATE AND HOUR OF DEATH JULY 29, 1972 3:40 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229 | | A. STATE MARYLAND | | B. COUNTY BALTIMORE 21228 | |
| | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | E. STREET AND NUMBER 408 GRALAN ROAD | | 5300 | |
| 5. SEX MALE | 6. RACE CAUCASIAN | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 05/15/02 | 9. AGE (In years last birthday) 70 | 10. AGE (In years last birthday) 70 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STORE OWNER | | 10B. KIND OF BUSINESS OR INDUSTRY MUSIC | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME GEORGE FROEHLICH | | 14. MOTHER'S MAIDEN NAME LILLIE M. LAYDEN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 213-03-4380 | | 17. INFORMANT BALTO MD 21229 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 562.1 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Early liver cirrhosis. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE E. Coli sepsis + shock DUE TO, OR AS A CONSEQUENCE OF: (B) Diverticulitis DUE TO, OR AS A CONSEQUENCE OF: (C) ... | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH + 6 days. + 2 weeks. years. | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that XX (this hospital) attended the deceased from JUNE 24 19 72 to JULY 29 19 72, that XX (we) last saw the deceased alive on JULY 29 19 72 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) view the body after death. | | | | | |
| 23A. SIGNATURE J.J. Mol. | | 23B. DATE SIGNED 7/29/72 | | 23C. PHYSICIAN'S NAME (Type) J.J. Mol. | |
| 23D. ADDRESS ST AGNES HOSPITAL BALTO MD 21229 | | 23E. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue 21228 | | 23F. ADDRESS Witzke, 1630 Edmondson Avenue 21228 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/1/72 | | 24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | |
| 24D. LOCATION Baltimore, Maryland | | 24E. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 24F. NAME OF HEALTH DEPT. 720003 | |

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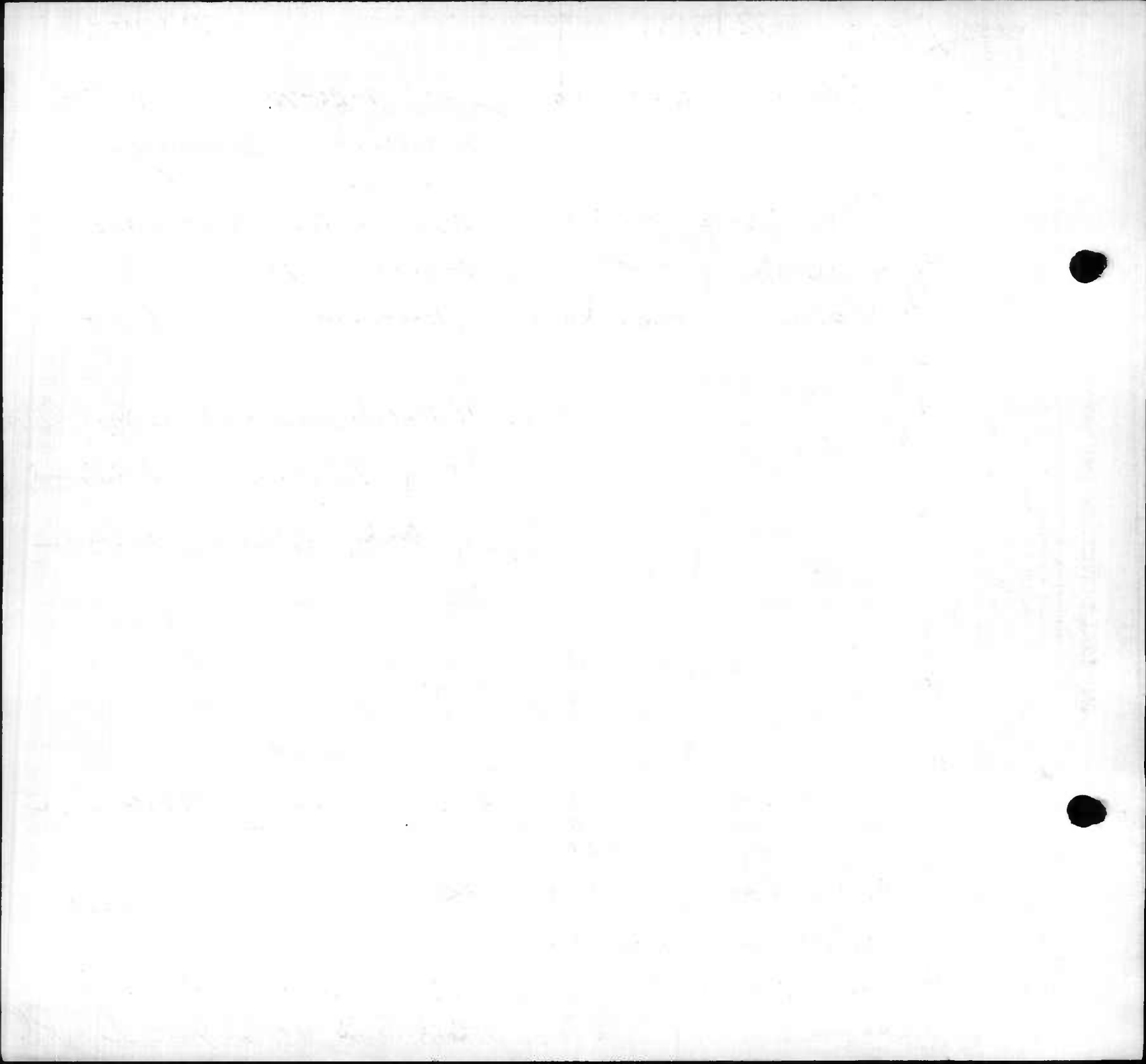
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

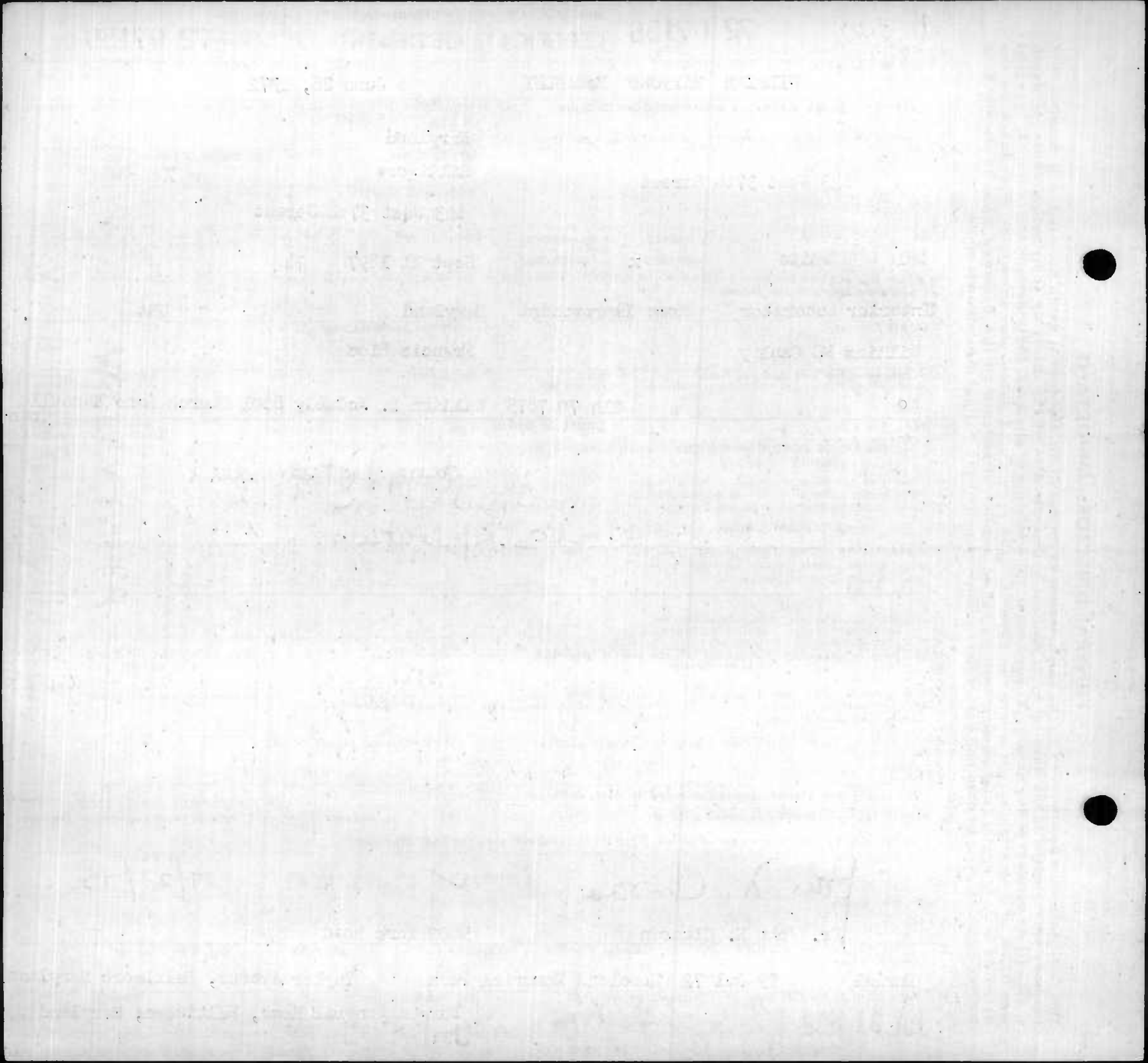
| | | | |
|--|---|--|--|
| 1. NAME OF DECEASED (Type or Print) <u>CARRIE J. LINTHICUM</u> | | 2. DATE AND HOUR OF DEATH <u>7-26-72</u> <u>4:15 A.M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>40 St. Agnes Hospital</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>ARBUTUS</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1233 Maiden Choice Lane</u> | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-30-93</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>OWN Home</u> | 9. AGE (In years last birthday) <u>78</u> |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>620-05-5901</u> | |
| 17. INFORMANT <u>MINERVA L. WEISER BORN</u> | | ADDRESS <u>1233 Maiden Choice</u> | |
| 18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE <u>Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Cerebral Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Instantaneous</u> | |
| 19A. DATE OF OPERATION <u>0</u> | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) <u>No</u> | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>6/1</u> 19 <u>64</u> to <u>7/26</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>7/26</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <u>Cliff Ratliff Jr. MD</u> | | 23B. DATE SIGNED <u>7/27/72</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Cliff Ratliff Jr. MD</u> | | 23D. ADDRESS <u>5722 Westview Mall</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>7-28-72</u> | 24C. NAME OF CEMETERY or CREMATORY <u>Oaklawn Cemetery</u> | 24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u> |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 31 1972</u> | | 25B. NAME OF REGISTRAR <u>Andrew W. Burton</u> | |
| 25C. FUNERAL DIRECTOR <u>Amick & Sons</u> | | ADDRESS <u>1320 S. Spring Rd.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>72 07156</u> |
|--|-------------------------|---|---|--|
| 72 07156 | | | | STATE OF MARYLAND-DHMH |
| BIRTH NO. <u>M-240</u> | | 72 07156 | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | |
| WILLIAM RAYMOND McCauley | | June 26, 1972 | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>00 843 West 37th Street</u> | | A. STATE <u>Maryland</u> | | |
| | | B. COUNTY <u>1307</u> | | |
| C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | E. STREET AND NUMBER <u>843 West 37th Street</u> | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 11 1897</u> | 9. AGE (In years last birthday) <u>74</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interior Decorator</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Home Improvement</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> |
| 13. FATHER'S NAME <u>William MC Cauley</u> | | 14. MOTHER'S MAIDEN NAME <u>Francis Rice</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>214 70 7875</u> | | 17. INFORMANT <u>William R. McCauley</u> |
| | | | | ADDRESS <u>8801 Church Lane Randalls town</u> |
| 18. <u>154.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>dehydration and malnutrition</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Ca of Rectum</u> | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <u>Dr. John N. Classen</u> | | 23B. DATE SIGNED <u>7/28/72</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Dr. John N. Classen</u> | | 23D. ADDRESS <u>5802 York Road</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>29 Jul 72</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Moreland Memorial Park</u> |
| 24D. LOCATION <u>Taylor Avenue, Baltimore Maryland</u> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 31 1972</u> | | 25B. NAME OF REGISTRAR <u>David J. [Signature]</u> | | 25C. FUNERAL DIRECTOR <u>Burgee Funeral Home, Baltimore, Maryland</u> |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-452 72 07157 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07157 | |
|---|------------------|---|--|---|---------------------------------|---|------------------------------|
| BIRTH NO. | | | | STATE OF MARYLAND - DHMH | | | |
| 1. NAME OF DECEASED (Type or Print) LINWOOD BLANCHARD | | | | 2. DATE AND HOUR OF DEATH July 25, 1972 4:30 A. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Ardleigh Nursing Home 2095 Rockrose Avenue | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1348 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4232 Falls Road | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH March 19 1905 67 | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Produce Sales | | 10B. KIND OF BUSINESS OR INDUSTRY Food Store | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME - Blanchard | | | | 14. MOTHER'S MAIDEN NAME Sammie Ella Simms | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No - | | 16. SOCIAL SECURITY NO. 214 18 2714 | | 17. INFORMANT ADDRESS Evelyn V. Pfeil 236 Riverthorn Rd | | | |
| 18. 412.34 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Arteriosclerotic cardio-vascular disease DUE TO, OR AS A CONSEQUENCE OF: (B) Old myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: (C) Diabetes mellitus (mild) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 5 yrs. 3 yrs. | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 22, 1968 to July 25, 1972, that (I) (we) last saw the deceased alive on July 19, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Lloyd E. Saylor, M.D. | | | | 23B. DATE SIGNED July 28, 1972 | | 23C. PHYSICIAN'S NAME (Type) Dr. Lloyd Saylor | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 28 Jul 72 | | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | | | 25B. NAME OF REGISTRAR Sidney Thornton | | 25C. FUNERAL DIRECTOR Burgess Funeral Home Baltimore Maryland | |
| 26A. DATE REC'D BY HEALTH DEPT. | | | | 26B. NAME OF REGISTRAR | | 26C. FUNERAL DIRECTOR ADDRESS Burgess Funeral Home Baltimore Maryland | |

72 07158

STATE OF MARYLAND-DHMH
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07158

BIRTH NO.

REG. NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) RICHARD BENNY HOWARD | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 103 N. Montford Avenue | | 3. DATE PRONOUNCED DEAD Month Day Year Hour July 26, 1972 8:45 P. | |
| 6. SEX Male | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 2/22/1942 | | 10. AGE (In years lost birth) 30 | |
| 11. BIRTHPLACE (State or foreign country) Georgia | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 17. SOCIAL SECURITY NO. 254 64 0054 | |
| 18. INFORMANT Mr. Wm. J. Arnold Box 83 Hanover Md. | | ADDRESS | |
| 19. E 965X | | CAUSE OF DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE Shotgun wound of abdomen DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ? | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? ? | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) ? | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Shot by unknown assailant | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Marvin S. Platt EXAMINER'S NAME (Type) | | DATE SIGNED July 27, 1972 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/30/72 | |
| 24C. NAME OF CEMETERY or CREMATORY Cross Roads Baptist Church Cemetery | | 24D. LOCATION (City, town, or county) (State) Dallas, Pauling Cty. Ga. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Raymond C. Fink | |
| 25C. FUNERAL DIRECTOR Raymond C. Fink | | ADDRESS Glen Burnie, Md. | |

5115

052



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| P-630 | | 72 07159 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07159 | |
| BIRTH NO. | | PRUITT, CYRUS RUDE | | REG. NO. | | STATE OF MARYLAND - DUNE | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | July 28, 1972 | | 9:00 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE Maryland | | B. COUNTY Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21211 | | C. CITY OR TOWN Rosedale | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 5300 | |
| E. STREET AND NUMBER 8326 Old Philadelphia Rd. | | 5. SEX Male | | 6. RACE Caucasian | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 8. DATE OF BIRTH Aug 5, 1918 | | 9. AGE (In years last birthday) 53 | | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Govt. | | 10B. KIND OF BUSINESS OR INDUSTRY Civil Services Clerk | | 11. BIRTHPLACE (State or foreign country) W. Virginia | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME William Bruitt | | 14. MOTHER'S MAIDEN NAME Willa Ann Greyhouse | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 10-21-42 to 2-16-46 | | 16. SOCIAL SECURITY NO. 285-14-1146 | |
| 17. INFORMANT Records V. A. Hospital | | ADDRESS 3900 Loch Raven Blvd., Baltimore, Md. 21218 | | 18. 157.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH cardiopulmonary collapse (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) metastatic carcinoma of pancreas (C) ascites and liver failure | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | 19A. DATE OF OPERATION 7/12/72 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED biliary obstruction | |
| 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) no | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (A) (this hospital) attended the deceased from July 3, 1972 to July 28, 1972, and that (B) (we) last saw the deceased alive on July 28, 1972 and that in (C) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE Hugh B. Robinson MD | | 23B. DATE SIGNED 7-28-72 | | 23C. PHYSICIAN'S NAME (Type) HUGH B. ROBINSON, M. D. | |
| 23D. ADDRESS V. A. Hospital 3900 Loch Raven Blvd., Baltimore, Md. | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/31/72 | | 24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Sidney W. Robinson | | 25C. FUNERAL DIRECTOR Richard B. Bruzdinski | |
| 25D. ADDRESS Bruzdinski Funeral Home 1407 Eastern Ave. | | VS 150-REV. 1/1/68 | | | | | |

21

1911

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1911

72 07160

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07160

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Elenor Leonard | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 7 24 72 | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 106 W. University Pkwy. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 24 72 12:45 a. | |
| 6. SEX female | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1201 | |
| 9. DATE OF BIRTH APR. 29, 1904 | | 10. AGE (In years last birthday) 68 | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WILLIAM H. STAUB SR. | | 14. MOTHER'S MAIDEN NAME RICNA JOHNSON | |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES LADY | | 16. KIND OF BUSINESS OR INDUSTRY | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 18. SOCIAL SECURITY NO. 213-20-5741 | |
| 19. 412-4 | | 18. INFORMANT WILLIAM H. STAUB JR | |
| 20. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | 21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/25/72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION | | 24B. DATE 7/28/72 | |
| 24C. NAME OF CEMETERY or CREMATORY LODGE PK CEM | | 24D. LOCATION (City, town, or county) (State) BALTO Md | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Adrienne H. Hooton | |
| 25C. FUNERAL DIRECTOR M. T. HELL-WIEDEFELD | | 25D. ADDRESS 6500 York Rd | |

• 17.

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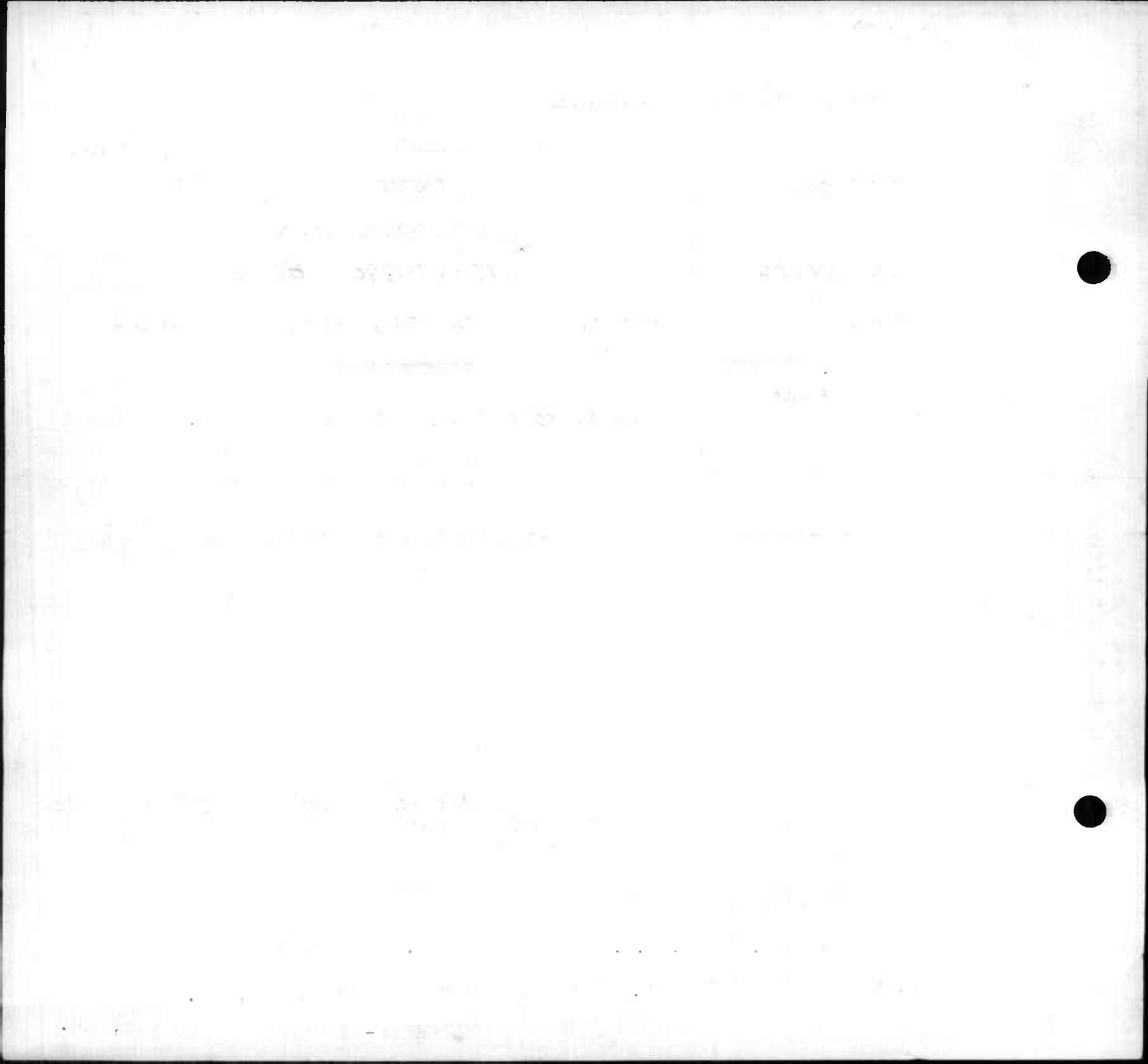
1. *Chlorophyll a* (Chl a) and *Chlorophyll b* (Chl b) are the two main photosynthetic pigments in green plants. They are responsible for capturing light energy and converting it into chemical energy through the process of photosynthesis. Chl a is the primary pigment, while Chl b acts as an accessory pigment, transferring energy to Chl a.

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

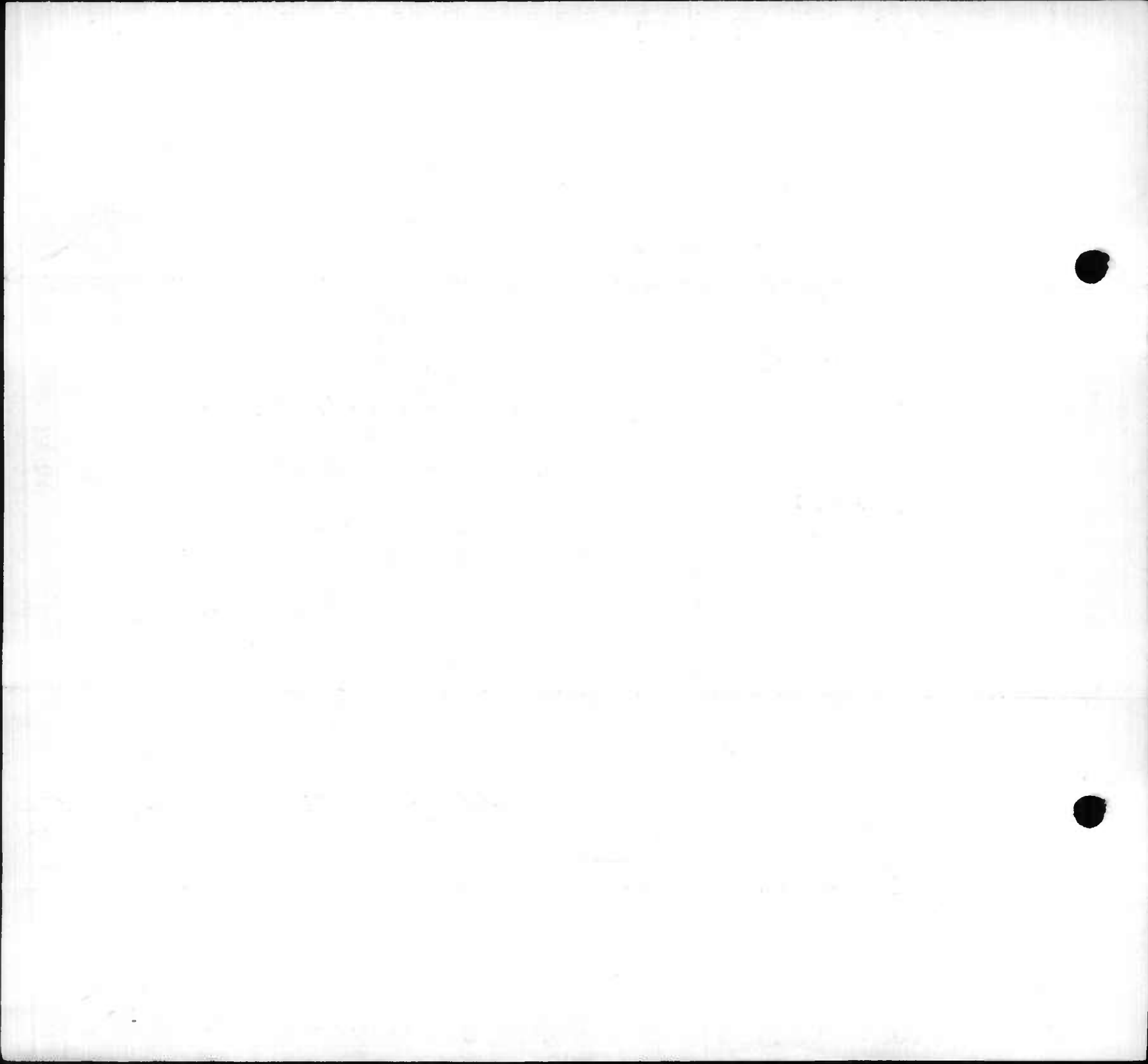
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 72 07161 STATE OF MARYLAND-DHMH | |
|--|-------------------------|---|---------------------------------------|--|---|
| D-250 72 07161 | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>Mary Wilson Dushane</u> | | 2. DATE AND HOUR OF DEATH <u>7-27-72</u> <u>16²⁰ AM</u> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1401</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>KESWICK HOME</u> <u>91</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER <u>1732 Bolton Street</u> | | | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-27-1890</u> | 9. AGE (In years last birthday) <u>81 yrs.</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>none</u> | | 11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>WILLIAM T. DUSHANE</u> | | 14. MOTHER'S MAIDEN NAME <u>NANNIE LOGAN</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>218-52-0538</u> | | 17. INFORMANT <u>KESWICK RECORDS</u> ADDRESS <u>700 W. 40th Street</u> | |
| 18. <u>431.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral Hemorrhage</u> (B) <u>Generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>many yrs</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <u>March 19 39</u> to <u>27 July 1972</u> and that (I) (we) last saw the deceased alive on <u>27 July 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <u>Harold P. Biehl</u> | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) <u>HAROLD P. BIEHL, M.D.</u> | |
| 23D. ADDRESS <u>700 W. 40th Street</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>7/29/72</u> | |
| 24C. NAME OF CEMETERY or CREMATORY <u>Mt. Olivet Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 31 1972</u> | |
| 25B. NAME OF REGISTRAR <u>Lidney</u> | | 25C. FUNERAL DIRECTOR <u>MITCHELL-WIEDEFELD</u> | | ADDRESS <u>6500 York Rd.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

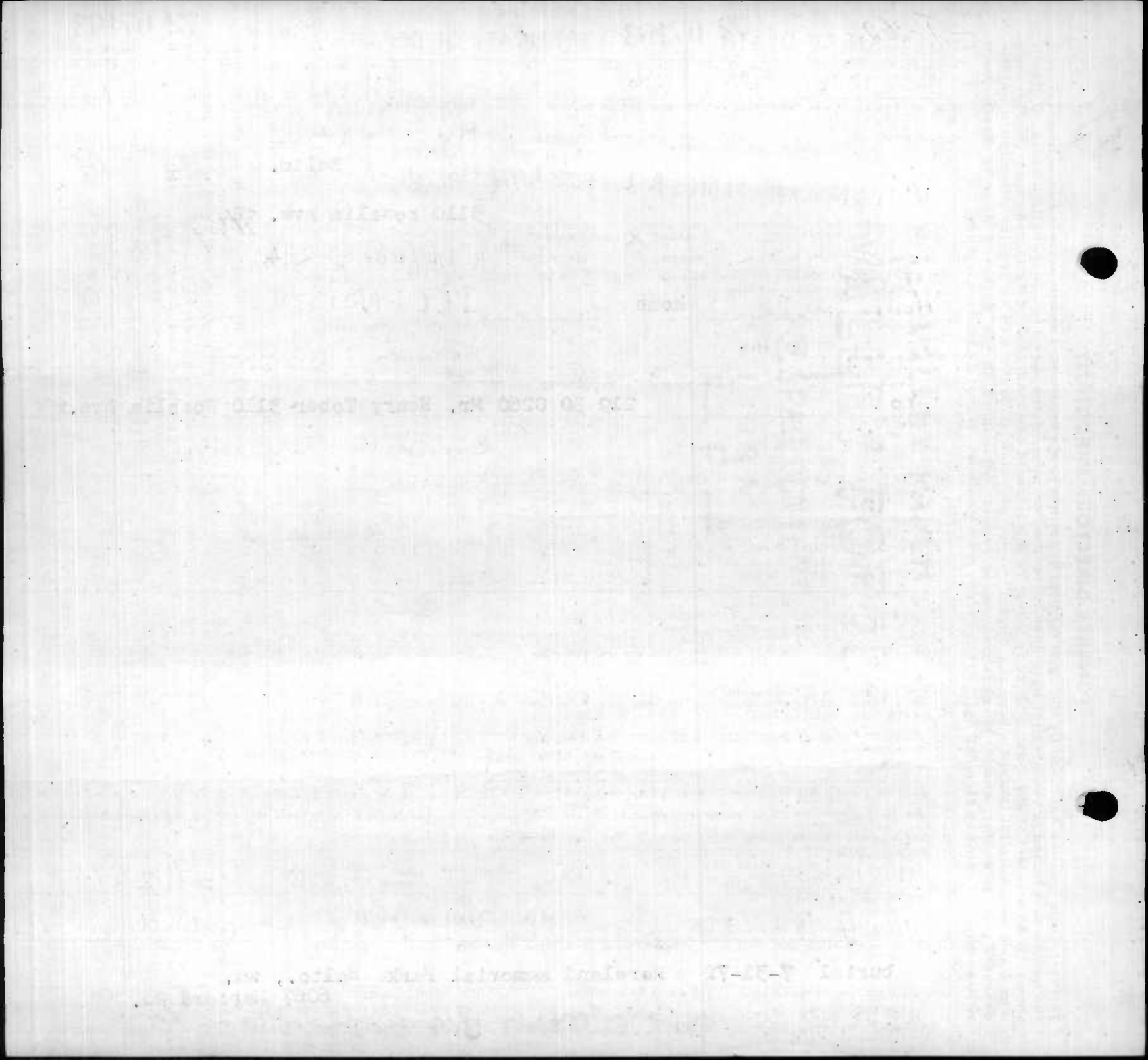
| | | | | | |
|--|---------------------|--|--|--|---|
| 7-432 72 07162 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 72 07162 STATE OF MARYLAND-DIGRA | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>SUSAN E. Fletcher</i> | | 2. DATE AND HOUR OF DEATH <i>7-28-72</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>2102</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>1241 SARGENT ST.</i> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <i>BALTIMORE</i> | |
| | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER <i>1241 SARGENT ST.</i> | |
| 5. SEX <i>F.</i> | 6. RACE <i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>12-8-04</i> | 9. AGE (In years last birthday) <i>67</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CLERK</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>RET.</i> | | 11. BIRTHPLACE (State or foreign country) <i>MD.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME <i>Charles E. LeBoer</i> | | | |
| 14. MOTHER'S MAIDEN NAME <i>SARA Brockhill</i> | | 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | |
| 16. SOCIAL SECURITY NO. <i>213-32-8442</i> | | 17. INFORMANT <i>FAMILY - Same</i> | | | |
| 18. <i>156.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Carcinoma Hepatic duct</i> DUE TO, OR AS A CONSEQUENCE OF: <i>& obstructive jaundice</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <i>7-31-72</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) 1 Month () 1 Day () 1 Year () 1 Hour () | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>April 19 1972</i> to <i>July 28 1972</i> that (I) (we) last saw the deceased alive on <i>July 19 1972</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Colmundo V. Gougeon MD</i> | | 23B. DATE SIGNED <i>7-28-72</i> | | 23C. PHYSICIAN'S NAME (Type) <i>Colmundo V. Gougeon MD</i> | |
| 23D. ADDRESS <i>130 E. Fort Dr.</i> | | 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>7-31-72</i> | | | |
| 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY <i>GREEN HAVEN</i> | | 24D. LOCATION (City, town, or county) (State) <i>BALTIMORE</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JUL 31 1972</i> | | 25B. NAME OF REGISTRAR <i>Aileen W. [unclear]</i> | | 25C. FUNERAL DIRECTOR <i>130 E. Fort Dr.</i> | |



FUNERAL DIRECTOR: IMPORTANT

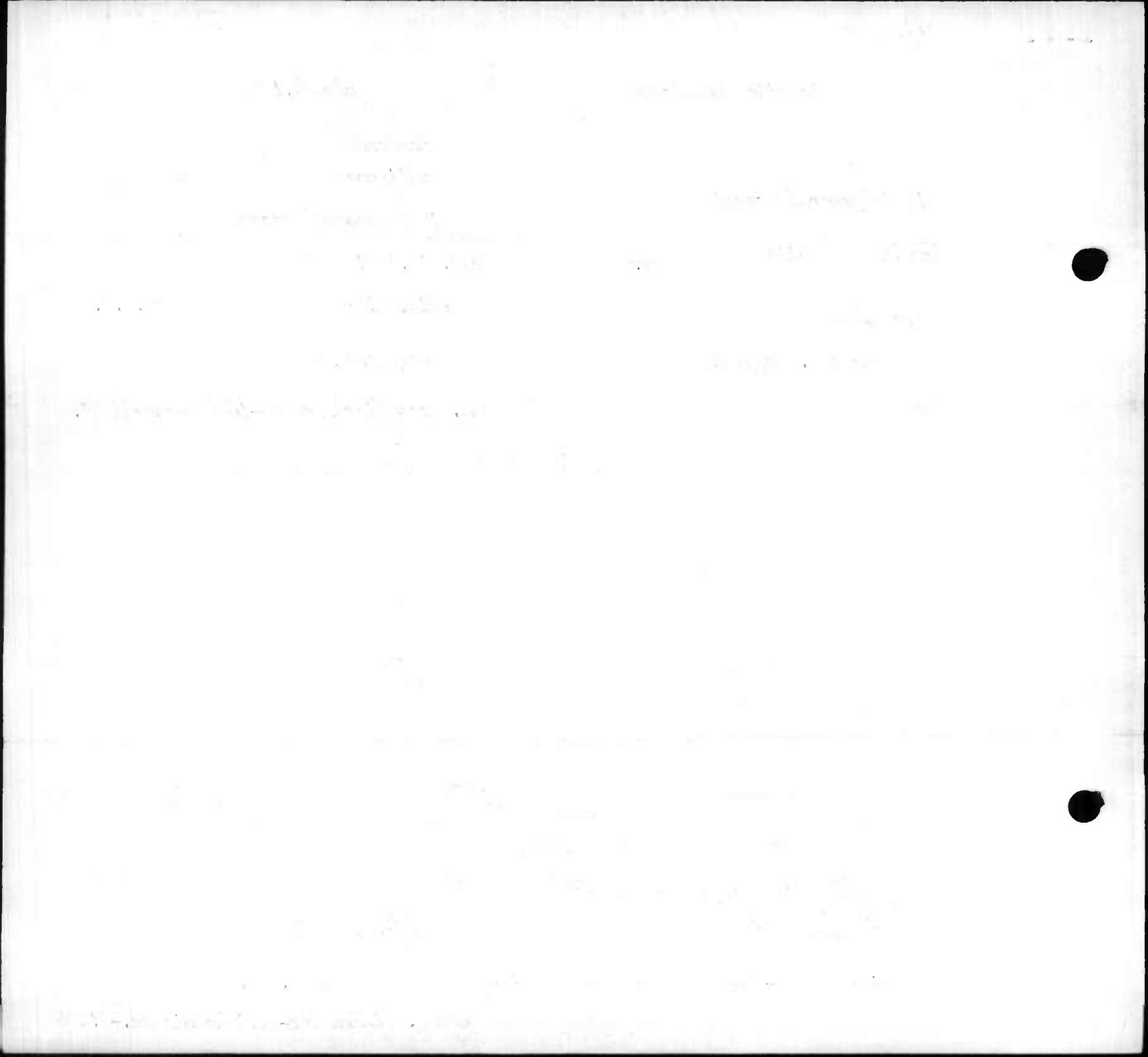
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|-------------------------|---|---|---|---|--|---|
| T-160 | | 72 07163 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07163 | |
| BIRTH NO. | | 72 07163 | | REG. NO. | | 72 07163 | |
| 1. NAME OF DECEASED (Type or Print) TOBER, MARY NMN | | | | 2. DATE AND HOUR OF DEATH 7/27/72 7 45 AM. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY U.S.A. C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3110 Rosalia Ave. 21234 | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/11/08 | 9. AGE (In years last birthday) 64 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife |
| 11. BIRTHPLACE (State or foreign country) ILLINOIS | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | | | | |
| 13. FATHER'S NAME Joseph THOMAS | | | 14. MOTHER'S MAIDEN NAME Unknown | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | 16. SOCIAL SECURITY NO. 219 30 0260 | | 17. INFORMANT Mr. Henry Tober 3110 Rosalia Ave. 2 | | ADDRESS |
| 18. 436.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Cerebro Vascular Accident ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | CAUSE OF DEATH Cerebro Vascular Accident APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-27-72 1972 to 7-27 1972, that (I) (we) last saw the deceased alive on 7-27-72 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE M. S. Hockair | | | | 23B. DATE SIGNED 7/27/72 | | | |
| 23C. PHYSICIAN'S NAME (Type) MAWYA SHOCKAIR | | | | 23D. ADDRESS MD. UNION MEMORIAL Hosp. Baltimore Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 7-31-72 | | 24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park | | 24D. LOCATION (City, town, or county) (State) Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Anthony [Signature] | | 25C. FUNERAL DIRECTOR 6067 Harford Rd. [Signature] | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 72 07164 BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07164 | | | |
|---|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. STATE OF MARYLAND-DHMH | | | |
| BIRTH NO. <i>M-623</i> | | | | 1. NAME OF DECEASED (Type or Print) <i>Birdella Murgatroyd</i> | | | |
| 2. DATE AND HOUR OF DEATH <i>July 24, 1972</i> | | | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | |
| A. STATE <i>Maryland</i> | | | | <i>1638 Carswell Street</i> | | | |
| B. COUNTY | | | | C. CITY OR TOWN <i>Baltimore</i> | | | |
| D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | E. STREET AND NUMBER <i>1638 Carswell Street</i> | | | |
| 5. SEX <i>Female</i> | | 6. RACE <i>White</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>Sept. 13, 1881</i> | |
| 9. AGE (In years last birthday) <i>90</i> | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home Maker</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Balto. City</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>George W. McCulloh</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Mary Canoles</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>Mrs. Mary Ethel Kampes-1838 Carswell St.</i> | |
| 18. <i>412.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH <i>Arteriosclerotic Cardio-Vascular Disease</i> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Several years</i> | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) <i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (This hospital) attended the deceased from <i>July 17, 1972</i> to <i>July 24, 1972</i> that (I) (We) last saw the deceased alive on <i>July 17, 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Loy M. Zimmerman M.D.</i> | | | | 23B. DATE SIGNED <i>7/26/72</i> | | 23C. PHYSICIAN'S NAME (Type) <i>Loy M. Zimmerman M.D.</i> | |
| 24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) <i>Burial 7-27-72</i> | | | | 24C. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JUL 31 1972</i> | | | | 25B. NAME OF REGISTRAR <i>John C. Miller Inc.</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>6415 Belair Rd. -21206</i> | |



M-600

72 07165

STATE OF MARYLAND-DEATH
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07165

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Ida Moore | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 7 Day 24 Year 72 Hour M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2223 E. Biddle Street | | 3. DATE PRONOUNCED DEAD Month 7 Day 24 Year 72 Hour 1:15 p.m. | |
| 6. SEX female | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH Aug. 10, 1887 | | 10. AGE (In years last birthday) 84 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Balto. Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress | | 14B. KIND OF BUSINESS OR INDUSTRY Retired | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 220-01-8500 | |
| 18. INFORMANT Mr. George P. Kammer | | ADDRESS 4 Whitethorn Rd. #1220 | |
| 19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 22G. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/25/72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-28-72 | |
| 24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Sidney H. Heston | |
| 25C. FUNERAL DIRECTOR John C. Miller Inc. | | ADDRESS 6415 Belair Rd. -21206 | |

55-26-2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07166 | |
|---|--|---|---|--|---|
| 72 07166 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. R-160 | | 1. NAME OF DECEASED (Type or Print) Manuel Rivera | | 2. DATE AND HOUR OF DEATH 7/27/72 M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2714 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 1126 Roland Hgts Ave. | | | C. CITY OR TOWN Balto. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX Male | | | 6. RACE Cauc. | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH 4/27/01 | | 9. AGE (In years last birthday) 71 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kiln Operator. | |
| 11. BIRTHPLACE (State or foreign country) Spain | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME ? | |
| 14. MOTHER'S MAIDEN NAME ? | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 215-09-7199 | |
| 17. INFORMANT Mrs. Laura Rivera | | ADDRESS (same) | | | |
| 18. CAUSE OF DEATH 4/10-9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 2 years | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/10 1971 to 7/27 1972 , that (I) (we) last saw the deceased alive on 7/14 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Leonard Wallenstein | | | | 23B. DATE SIGNED 7/28/72 | |
| 23C. PHYSICIAN'S NAME (Type) L. WALLENSTEIN M.D. | | | | 23D. ADDRESS 848 W 36 TH BALTO 21211 MS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/31/72 | | 24C. NAME OF CEMETERY or CREMATORY Lorraine Park | |
| 24D. LOCATION Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | | |
| 25B. NAME OF REGISTRAR Paul E. Chenoweth | | 25C. FUNERAL DIRECTOR Paul E. Chenoweth 3rd. 3617 Chestnut Ave. | | | |

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BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES W. LAMBERT, JR.

2. DATE OF DEATH
Known ☐ Month Day Year Hour
Estimated ☐ M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 200 blk. Fulton St. at Pratt St.

3. DATE PRONOUNCED DEAD
Month Day Year Hour
7 29 1972 2:14a M.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 1903

6. SEX

male

7. RACE

white

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

2/14/48

10. AGE (In years last birthday)

24

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1636 Mc Henry St.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Charles William Lambert, Sr.

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Carpenter

14B. KIND OF BUSINESS OR INDUSTRY

Contracting

15. MOTHER'S MAIDEN NAME

Genevieve Judy

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.
234-76-4684

18. INFORMANT

Karen E. Lambert 1634 McHenry Street

ADDRESS

21223

19. E966X

CAUSE OF DEATH

Stabwound of chest

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
street22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
200 blk. 1 Fulton St. at Pratt St. 190322D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)
7-29-72 2 a

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Stabbed during argument.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Marvin S. Platt M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-29-72

24A. BURIAL CREMATION, REMOVAL (Specify)
Burial

24B. DATE

8/1/72

24C. NAME of CEMETERY or CREMATORY

Crest Lawn Gardens

24D. LOCATION (City, town, or county) (State)

Howard Co., Maryland

25A. DATE REC'D BY HEALTH DEPT.

JUL 31 1972

25B. NAME OF REGISTRAR

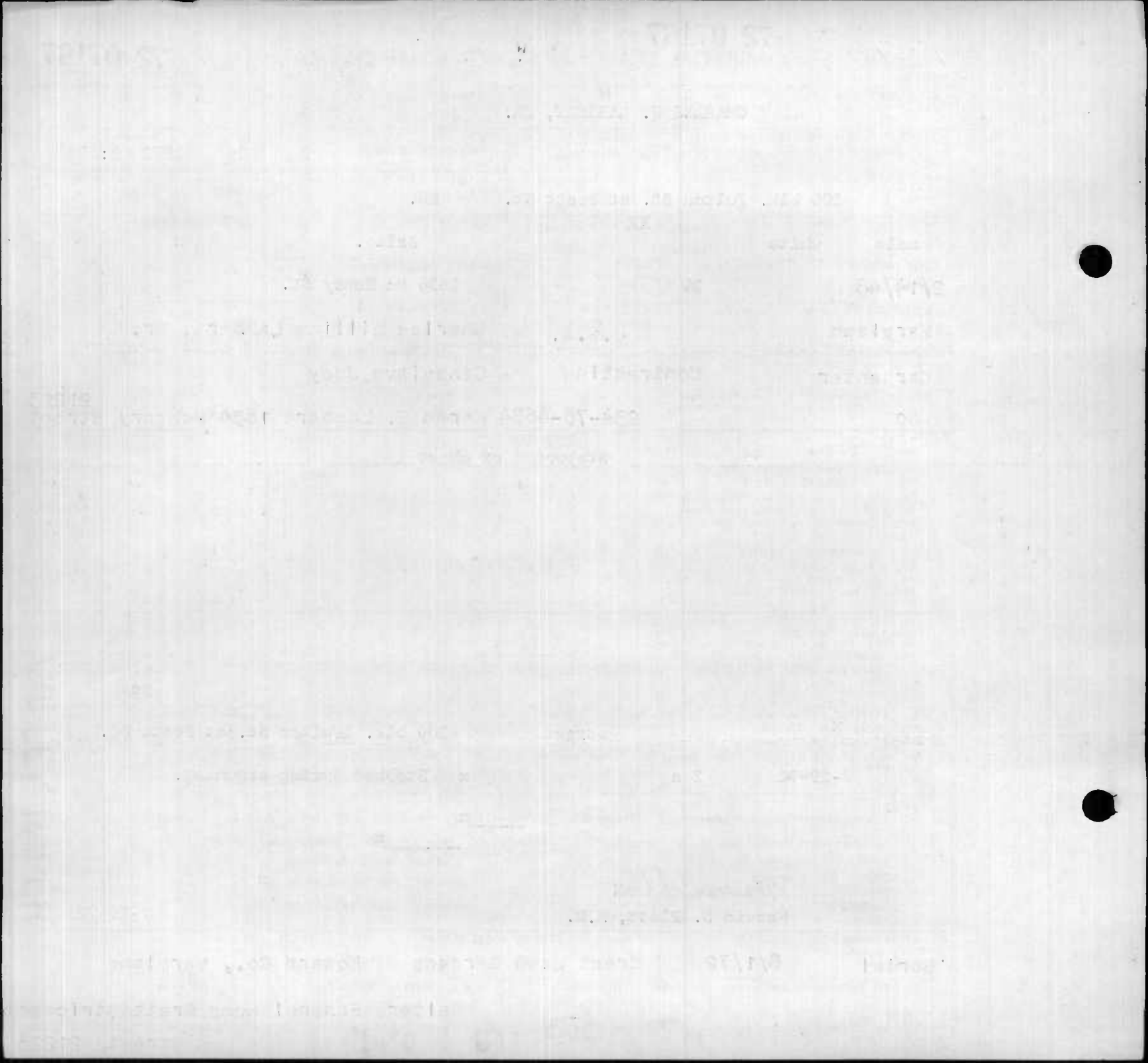
Sidney J. [Signature]

25C. FUNERAL DIRECTOR

Walters Funeral Home Pratt & Stricker

ADDRESS

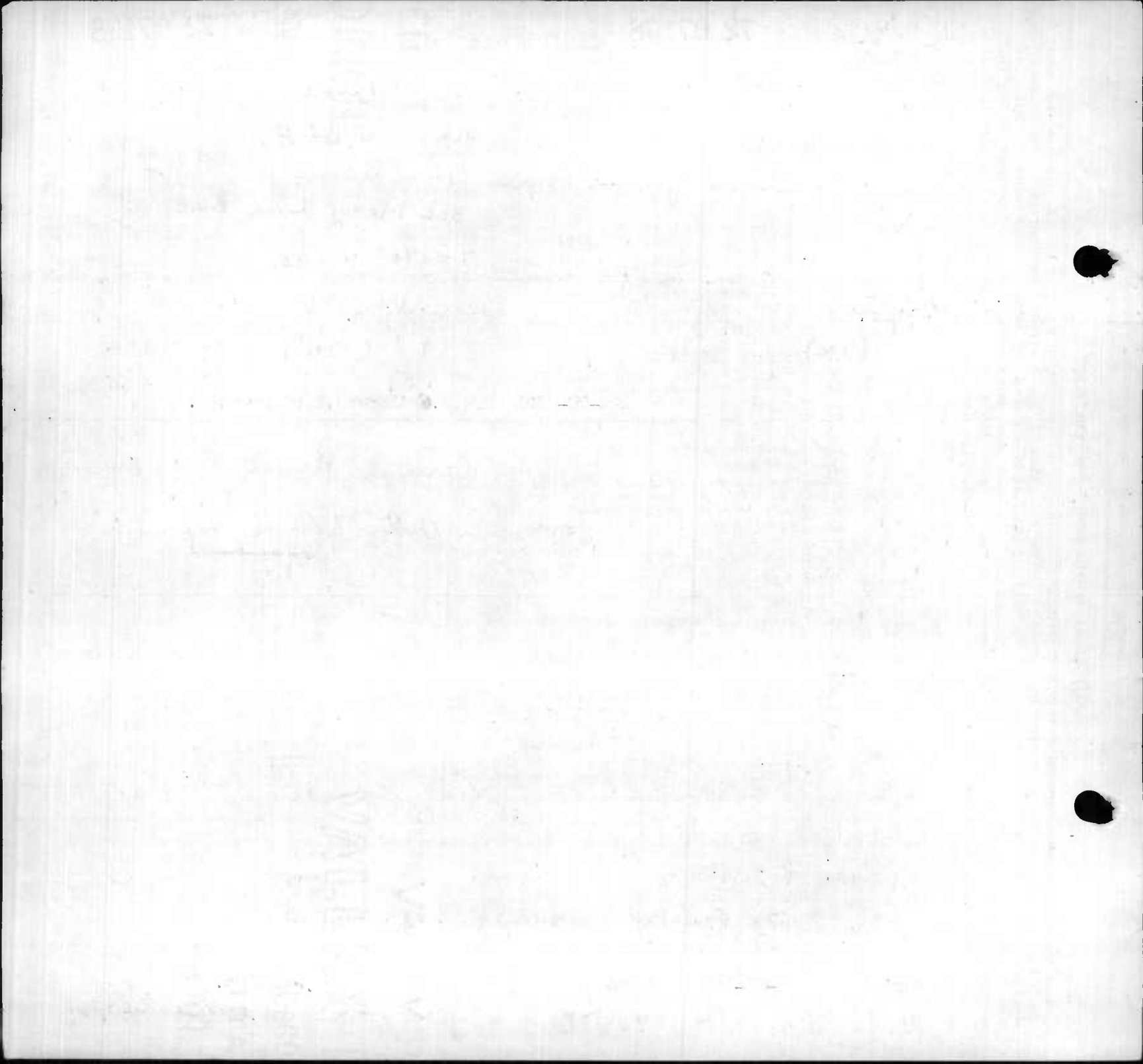
Streets 21223



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

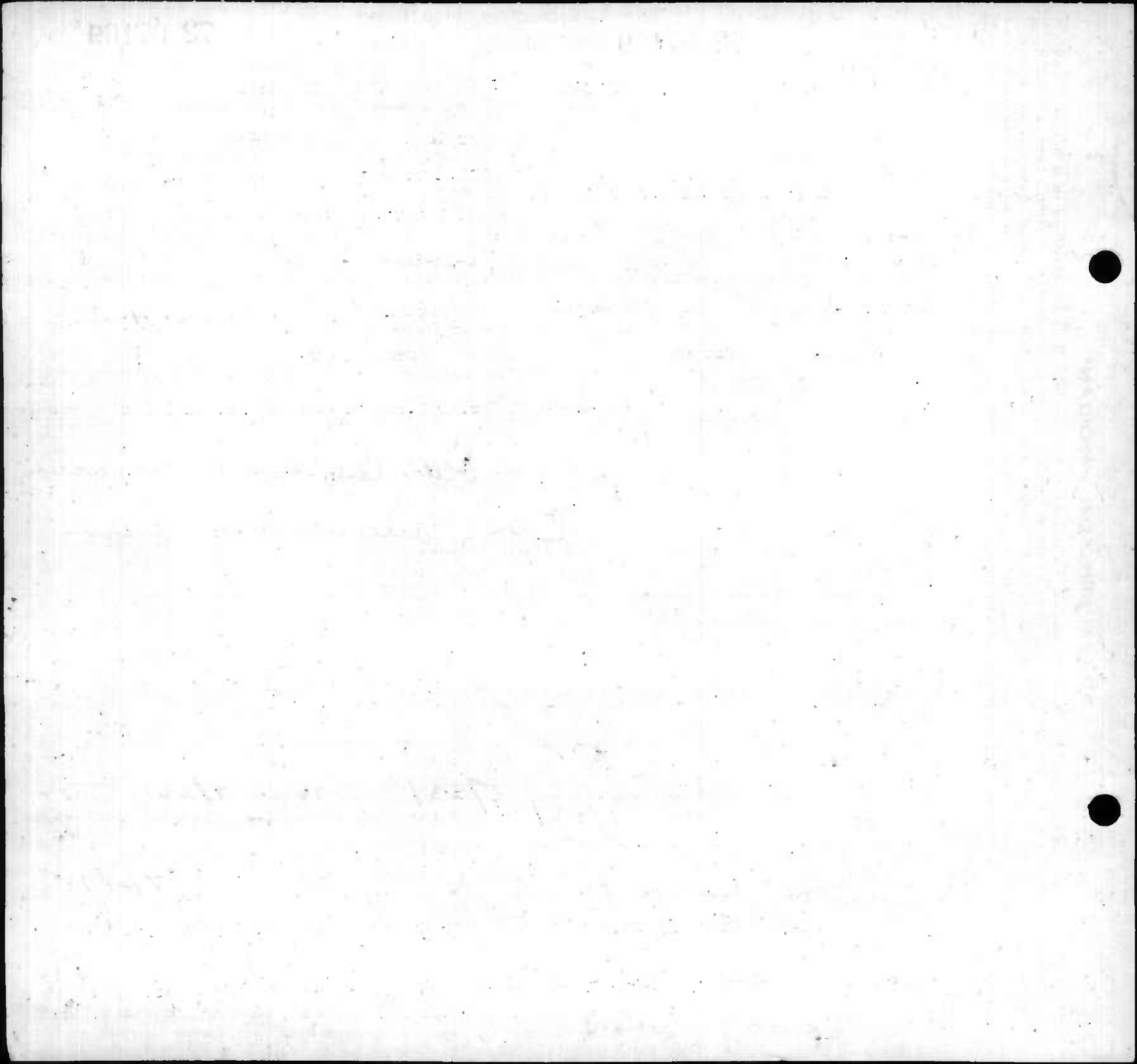
| | | | | | | | |
|---|---------------|---|--|--|---------------------------------------|---|--|
| C-436 | | 72 07168 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07168 | |
| BIRTH NO. | | 72 07168 | | STATE OF MARYLAND-DHMH | | | |
| 1. NAME OF DECEASED (Type or Print) CHILDRESS GRACE LEE. | | | | 2. DATE AND HOUR OF DEATH 7-28-72 7:10 p.m. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE md. | | B. COUNTY A.A. | |
| South Baltimore General Hospital | | 43 | | C. CITY OR TOWN Glen Burnie | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 43 | | | | E. STREET AND NUMBER 304 Mary Lou Ave. | | | |
| 5. SEX F. | 6. RACE W. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7-5-96 | 9. AGE (In years lost birthday) 76 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Va. Rockbridge Co. Va. | |
| 13. FATHER'S NAME ? (Dec) Robert Leighton | | | | 14. MOTHER'S MAIDEN NAME ? (Dec) Ethelin Cheaton | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 228-79-6521 | | 17. INFORMANT Mrs. A. Childress, Sprigwood, Va. | |
| 18. 4/10-91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloting the UNDERLYING CONDITION lost. | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Arrest. (B) extensive Anterior lateral Myocardial Infarction. (C) - | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-21-1972 to 7-28-1972, that (I) (we) lost saw the deceased alive on 7-28-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE P. Sawney | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 7-28-72 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. PAVANST SAWNEY | | | | 23D. ADDRESS 3001, South Hanover St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-31-1972 | | 24C. NAME OF CEMETERY or CREMATORY Coppes | | 24D. LOCATION (City, town, or county) (State) Botetourt Co. Va | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Audrey Johnson | | 25C. FUNERAL DIRECTOR Slack Funeral Home, Baltimore City, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

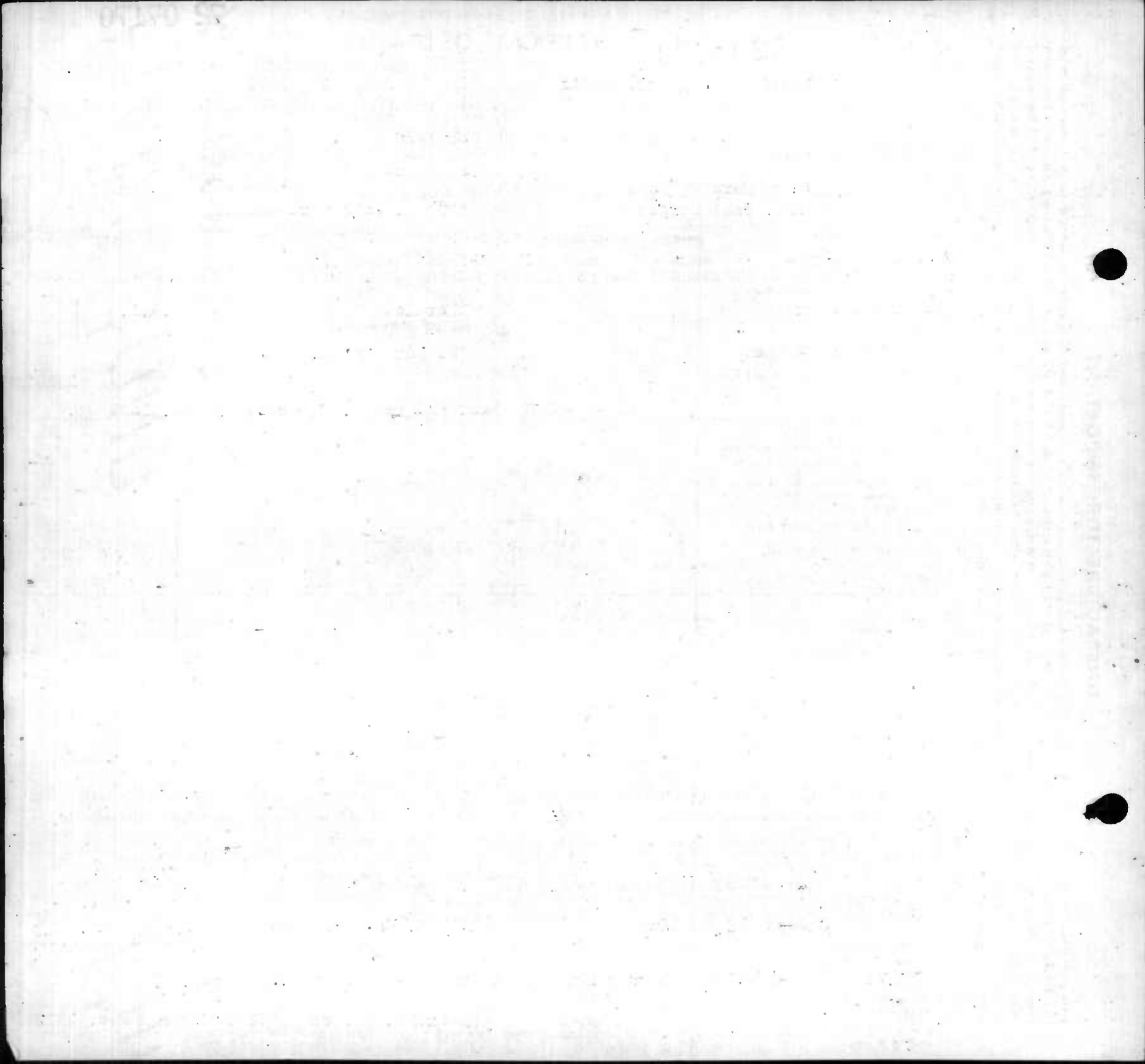
| | | | | | | | |
|---|---------|--|------------------|---|------------------------|--|------------------------------|
| C-636 | | 72 07169 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07169 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | STATE OF MARYLAND-DEMO | |
| | | HARRY F. CARTER | | July 26, 1972 | | 2:15 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE | | B. COUNTY | |
| 90 Caton Manor Nursing Home | | | | Maryland | | Howard | |
| | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | | | Ellicott City | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER | | | |
| | | | | 4002 Spring Meadow Drive | | 21043 | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months | 11. Under 24 Hrs. Days | 12. CITIZEN OF WHAT COUNTRY? |
| Male | White | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 4-22-1891 | 80 | | | U.S.A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Retired Machinist | | Davis & Hempel | | Maryland | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| William Carter | | | | Sarah Burns | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | 216-03-1900A | | Mr. William H. Carter, Sr. | | Dr. 21043 4002 Spring Meadow | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: acute Coronary Thrombosis immediate | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: Coronary atherosclerosis | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) _____ | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/23/1972 to 7/24/1972, that (I) (we) last saw the deceased alive on 7/23/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Cliff Ratliff, Jr. | | | | 7/27/72 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Cliff Ratliff, Jr. | | | | 5772 Westview Mall, Baltimore, Md. 21228 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 7-29-1972 | | Grace Episcopal Cemetery | | Elkridge, Howard Co., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | |
| JUL 31 1972 | | Sidney H. Hubbard | | Howard H. Hubbard | | 4107 Wilkens Ave. 21229 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

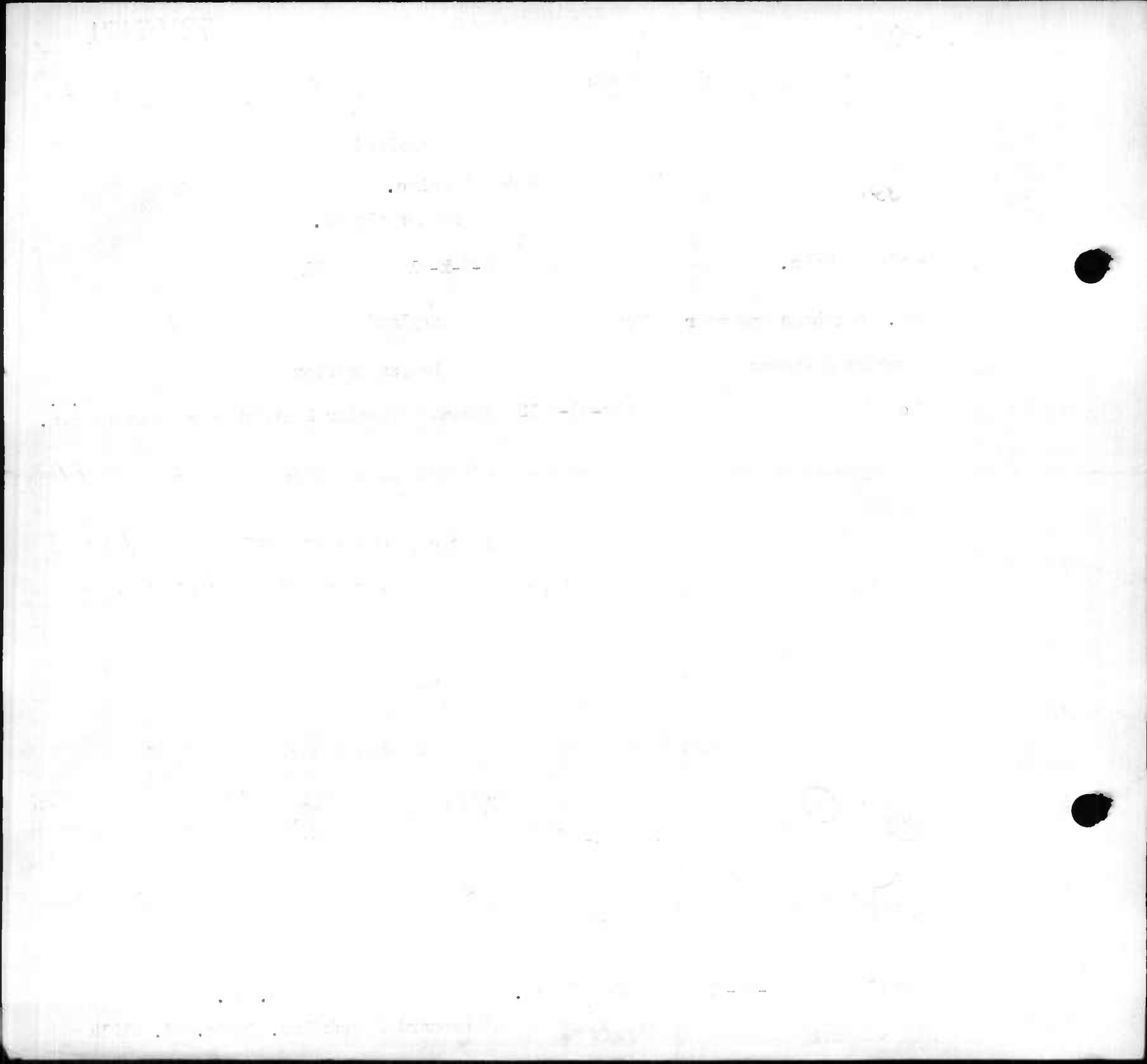
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07170 | |
|--|-------------------------|---|--|--|---|
| 72 07170 | | | | STATE OF MARYLAND - DEPT. OF HEALTH | |
| BIRTH NO. R-163 | | 1. NAME OF DECEASED (Type or Print) ESTELLE RUPPERTS BERGER | | 2. DATE AND HOUR OF DEATH July 27, 1972 | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Midtown Nursing Home 808 St. Paul Street | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1803 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1221 W. Baltimore Street | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 8-9-1890 | 9. AGE (In years lost birthday) 81 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Seamstress | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Walter Hughes | | 14. MOTHER'S MAIDEN NAME Esther Miller | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-54-3347 | | 17. INFORMANT ADDRESS Mrs. Mildred O. Roberts, 817 St. Paul St. 21202 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.41 Terminal Renal Insufficiency | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Terminal Renal Insufficiency (B) DUE TO, OR AS A CONSEQUENCE OF: A.S.C.U. Disease (C) _____ | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic Brain Syndrome | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/13 19 66 to 7/27/72 19 72 , that (I) (we) last saw the deceased alive on 7/27 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Joseph S. Blum | | | | 23B. DATE SIGNED 7/27/72 | |
| 23C. PHYSICIAN'S NAME (Type) Joseph S. Blum | | 23D. ADDRESS 1115 N. Calvert Street, Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-29-1972 | | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Audrey H. Hubbard | | 25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07171 | | 72 07171 | |
|--|-------------------------|---|---|--|--|---|--|
| J-525 | | | | 72 07171 | | 72 07171 | |
| BIRTH NO. | | | | REG. NO. | | STATE OF MARYLAND-DEMH | |
| 1. NAME OF DECEASED (Type or Print) <u>Dorothy C Jansen</u> | | | | 2. DATE AND HOUR OF DEATH <u>7/26/72</u> <u>830 A.</u> M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2864</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 University of Maryland</u> | | | | C. CITY OR TOWN <u>Balto.</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER <u>406 Edsdale Rd.</u> | | | | | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>Cauc.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-5-01</u> | | 9. AGE (In years last birthday) <u>71</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Telephone Operator</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>C&P</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Charles E Jansen</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Louisa Holston</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>212-03-6412</u> | | 17. INFORMANT <u>Norman C Sheeler 2 Ellyn Court Convent Sta. N.J.</u> | | | |
| 18. <u>244X I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | (A) IMMEDIATE CAUSE <u>Acute myocardial infarction</u> 70 days DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Hyp. thyroidism</u> 8 years DUE TO, OR AS A CONSEQUENCE OF: (C) <u>hypoadrenalism 20 to hypothyroidism</u> | | | |
| 19A. DATE OF OPERATION <u>2</u> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>7/16</u> 19 <u>72</u> to <u>7/26</u> 19 <u>72</u> that (1) (we) last saw the deceased alive on <u>7/26</u> 19 <u>72</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Louis S. Jansen</u> | | | | 23B. DATE SIGNED <u>7/26/72</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Leonard J. Ruck Inc.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 24B. DATE <u>7-29-72</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Parkwood Cem.</u> | |
| 24D. LOCATION <u>Balto. Md.</u> | | | | 24E. DATE REC'D BY HEALTH DEPT. <u>JUL 31 1972</u> | | 24F. NAME OF REGISTRAR <u>Audrey Holston</u> | |
| 24G. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc.</u> | | | | 24H. ADDRESS <u>Balto. Md. 21214</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------|---|-----------------------------------|---|---------------------------|--|----------------------------|--|------------------------------|
| CERTIFICATE OF DEATH | | | | | | | | | |
| BIRTH NO. | | 72 07172 | | REG. NO. | | 72 07172 | | | |
| STATE OF MARYLAND-DMH | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| BELLER, Robert James | | | | 7/27/72 | | | | 8:15 a.m. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE | | B. COUNTY | | | |
| | | | | Maryland | | Montgomery 6500 | | | |
| The Johns Hopkins Hospital | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | | | |
| | | | | Potomac 20854 | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | E. STREET AND NUMBER | | | | | |
| | | | | 8805 Wooden Bridge Road | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months | 11. If Under 24 Hrs. Days | 12. If Under 24 Hrs. Hours | 13. If Under 24 Hrs. Min. | |
| Male | Cauc. | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 7/1/12 | 60 | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY? |
| Retired attorney | | | Federal Trade Comm. | | | Washington, D.C. | | | USA |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| Walter Beller | | | | Jennie Breen | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| no | | | | | | Robert F. Beller (son) | | | |
| | | | | | | ADDRESS 20854 8216 Inverness Hollow Terr., Potomac, Md. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | Decompensatory post op partial resection of brain tumor | | | | 2 days | |
| ANTECEDENT CAUSES | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) Diffusate extensive glioma | | | | 2-3 mo | |
| | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 7/25/72 | | ASTROCYTOMA, INFILTRATIVE | | NO | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | | | |
| NO | | NO | | N.A. | | N.A. | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| N.A. | | N.A. | | N.A. | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/20 1972 to 7/27 1972 that (I) (we) last saw the deceased alive on 7/26 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | | | |
| Frederick H. Sklar M.D. | | | | 7/27/72 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| FREDERICK H. SKLAR M.D. | | | | JOHNS HOPKINS HOSPITAL, BALTIMORE, MD. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) | | (State) | |
| Burial | | 7/31/72 | | Resurrection Cemetery | | Clinton, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| JUL 31 1972 | | Arlene H. Sklar | | JOSEPH GAWLER'S SONS INC. | | 130 WISC. AVE., N. W. WASH., D. C. 20016 | | | |

Resident attorney Federal Trade Comm. Washington, D.C.

green

Robert F. Heller (son)

8316 Investment Hollow Ter.

no

attorney

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|---------|---|------------------|--|----------------------------|--|--|
| S-630 | | 72 07173 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07173 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | REG. NO. | | STATE OF MARYLAND - DEPT. HEALTH | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| EVA SIROTA | | | | JULY 26, 1972 | | 10:25 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE | | B. COUNTY | |
| PLEASANT MANOR NURSING HOME | | | | MARYLAND | | 2831 | |
| | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | | | BALTIMORE | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER | | | |
| | | | | 6524 EBERLE DRIVE | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months Days | | |
| FEMALE | WHITE | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9/10/1902 | 70X 69 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| HOUSEWIFE | | | | BALTIMORE, MARYLAND | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| ELLIS SIROTA | | | | ROSE ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | | | | | MR. ELLIS SIROTA, 4159 CRESTHEIGHTS RD. #15 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | | | Ante Pulmonary Embolism sudden | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) Anterior wall Acute Myocardial Infarction 6 years. | | | |
| | | | | (C) Diabetes Mellitus 20 years. | | | |
| 19. DATE OF OPERATION | | | | | | | |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | |
| 20A. AUTOPSY? (Yes or No) | | | | | | | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED | | | |
| | | | | White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | |
| 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 1966 to July 26 1972, that (I) (we) last saw the deceased alive on July 25 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| A. A. Silver | | | | July 27, 1972 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| A. A. SILVER | | | | 6210 PARK HEIGHTS AVENUE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| BURIAL | | | | 7/28/72 | | BETH ISAAC ADATH ISRAEL | |
| 24D. LOCATION (City, town, or county) (State) | | | | | | | |
| BALTIMORE, MARYLAND | | | | | | | |
| 25A. WAVE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JUL 31 1972 | | | | Sol Levinson | | SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|-------------------------|---|--|---|--|---|--|
| B-600 | | 72 07174 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07174 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | | | REG. NO. STATE OF MARYLAND-DEPT | |
| 1. NAME OF DECEASED (Type or Print) <u>Joseph Baer</u> | | | | 2. DATE AND HOUR OF DEATH <u>7/25/72</u> <u>1:50 P.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore City</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital</u> <u>Belvedere & Greenspring Ave</u> <u>Baltimore, Maryland 21115</u> | | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER <u>6984 Millbrook Park Drive, APT. B 1</u> | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>2/22/49</u> | 9. AGE (In years last birthday) <u>73 XXXXX</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARBER</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>SHOP</u> | | 11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>WILLIAM BAER</u> | | | | 14. MOTHER'S MAIDEN NAME <u>IDA ?</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>MR. LEONARD BAER, 322 CHERRY CHAPEL RD. #21136</u> | | | |
| 18. <u>493X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Starvo-Pulmonary Arrest.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASTHMA</u> | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ASTHMA</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>July 23</u> 19 <u>72</u> to <u>July 25</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>July 25</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Robert Kroopnick, M.D.</u> | | | | 23B. DATE SIGNED <u>7/25/72</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>ROBERT KROOPNICK</u> | | | | 23D. ADDRESS <u>9008 Meadowheights Rd.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>7/27/72</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>CHIZUK AMUNO (ARLINGTON)</u> | | 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 31 1972</u> | | 25B. NAME OF REGISTRAR <u>Sydney M. London</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u> | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07175 STATE OF MARYLAND-DHMH |
|--|---|---|--|---|
| BIRTH NO. <div style="font-size: 1.5em; font-weight: bold;">M-352</div> <div style="font-size: 1.5em; font-weight: bold;">72 07175</div> | | <div style="font-size: 1.5em;">72 07175</div> CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) <div style="font-size: 1.2em; font-weight: bold;">FANNIE MITNICK</div> | | 2. DATE AND HOUR OF DEATH <div style="font-size: 1.2em; font-weight: bold;">JULY 27, 1972</div> <div style="font-size: 1.2em; font-weight: bold;">5:30 A.M.</div> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <div style="font-size: 1.2em; font-weight: bold;">JEWISH CONVALESCENT HOME</div> <div style="font-size: 1.5em; font-weight: bold;">90</div> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <div style="font-size: 1.2em; font-weight: bold;">MARYLAND</div> B. COUNTY <div style="font-size: 1.5em; font-weight: bold;">2716</div> C. CITY OR TOWN <div style="font-size: 1.2em; font-weight: bold;">BALTIMORE</div> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <div style="font-size: 1.2em; font-weight: bold;">4601 PALL MALL ROAD</div> | | |
| 5. SEX <div style="font-size: 1.2em; font-weight: bold;">FEMALE</div> | 6. RACE <div style="font-size: 1.2em; font-weight: bold;">WHITE</div> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <div style="font-size: 1.2em; font-weight: bold;">12/5/1896</div> | 9. AGE (In years lost birthday) <div style="font-size: 1.2em; font-weight: bold;">75</div> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="font-size: 1.2em; font-weight: bold;">HOUSEWIFE</div> | | 10B. KIND OF BUSINESS OR INDUSTRY <div style="font-size: 1.2em; font-weight: bold;">AT HOME</div> | | 11. BIRTHPLACE (State or foreign country) <div style="font-size: 1.2em; font-weight: bold;">POLAND</div> |
| 13. FATHER'S NAME <div style="font-size: 1.2em; font-weight: bold;">JACOB SCHWARTZ</div> | | 14. MOTHER'S MAIDEN NAME <div style="font-size: 1.2em; font-weight: bold;">RACHEL NUSINOV</div> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <div style="font-size: 1.2em; font-weight: bold;">NO</div> | | 16. SOCIAL SECURITY NO. <div style="font-size: 1.2em; font-weight: bold;">212-01-0474D</div> | | 17. INFORMANT <div style="font-size: 1.2em; font-weight: bold;">MR. MAX SCHWARTZ, 7020 FIELDCREST ROAD #21215</div> |
| 18. CAUSE OF DEATH <div style="font-size: 1.5em; font-weight: bold;">I</div> <div style="font-size: 1.2em; font-weight: bold;">DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div> <div style="font-size: 1.2em; font-weight: bold;">(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</div> <div style="font-size: 1.2em; font-weight: bold;">ANTECEDENT CAUSES</div> <div style="font-size: 1.2em; font-weight: bold;">DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</div> <div style="font-size: 1.5em; font-weight: bold;">II</div> <div style="font-size: 1.2em; font-weight: bold;">OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</div> | | | | |
| 19A. DATE OF OPERATION <div style="font-size: 1.2em; font-weight: bold;">010/71</div> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <div style="font-size: 1.2em; font-weight: bold;">Cancer of sigmoid</div> | | 20A. AUTOPSY? (Yes or No) <div style="font-size: 1.2em; font-weight: bold;">NO</div> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <div style="font-size: 1.2em; font-weight: bold;">10/15</div> 1946 to <div style="font-size: 1.2em; font-weight: bold;">7/27</div> 1972 , that (I) (we) last saw the deceased alive on <div style="font-size: 1.2em; font-weight: bold;">7/26</div> 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <div style="font-size: 1.5em; font-weight: bold;">[Signature]</div> | | | | 23B. DATE SIGNED <div style="font-size: 1.2em; font-weight: bold;">7/27/72</div> |
| 23C. PHYSICIAN'S NAME (Type) <div style="font-size: 1.2em; font-weight: bold;">ISRAEL ZINBERG</div> | | 23D. ADDRESS <div style="font-size: 1.2em; font-weight: bold;">4000 W. NORTHERN PKWY.</div> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <div style="font-size: 1.2em; font-weight: bold;">BURIAL</div> | | 24B. DATE <div style="font-size: 1.2em; font-weight: bold;">7/28/72</div> | | 24C. NAME of CEMETERY or CREMATORY <div style="font-size: 1.2em; font-weight: bold;">AITZ CHAIM</div> |
| 24D. LOCATION (City, town, or county) (State) <div style="font-size: 1.2em; font-weight: bold;">BALTIMORE, MARYLAND</div> | | 25A. DATE REC'D BY HEALTH DEPT. <div style="font-size: 1.2em; font-weight: bold;">JUL 31 1972</div> | | |
| 25B. NAME OF REGISTRAR <div style="font-size: 1.2em; font-weight: bold;">[Signature]</div> | | 25C. FUNERAL DIRECTOR <div style="font-size: 1.2em; font-weight: bold;">SQL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</div> | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>72 07176</u> | |
|--|-------------------------|--|---------------------------------------|---|---|
| 72 07176 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. <u>Y-642</u> | | 1. NAME OF DECEASED (Type or Print) FANNIE YARLICK | | 2. DATE AND HOUR OF DEATH JULY 26, 1972 1:45 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2720 | | C. CITY OR TOWN BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION 3910 FALLSTAFF ROAD | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER 3910 FALLSTAFF ROAD | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/26/1909 | 9. AGE (In years last birthday) 62 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) WILKES BARRE, PA. | |
| 13. FATHER'S NAME MARCUS LEVIN | | 14. MOTHER'S MAIDEN NAME ANNA ? | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MR. DANIEL YARLICK, 3910 FALLSTAFF ROAD #21215 | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH Adenocarcinoma, uterus (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic granulocytic leukemia | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs. | |
| 19A. DATE OF OPERATION 09-69 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Above | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-18 19 58 to 7-26 19 72 , that (I) (we) last saw the deceased alive on 7-24 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Stanley R. Steinbach | | | | 23B. DATE SIGNED 7-26-72 | |
| 23C. PHYSICIAN'S NAME (Type) STANLEY R. STEINBACH | | | | 23D. ADDRESS 11 SLADE AVENUE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 7/27/72 | | 24C. NAME OF CEMETERY or CREMATORY NEW HAR SINAI | |
| 24D. LOCATION (City, town, or county) (State) REISTERSTOWN, MARYLAND | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Lidley | | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN RD. | |

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72 07177

STATE OF MARYLAND-DEMH
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07177

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) EUGENE BARNEY | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3206 St. Paul Street | | 3. DATE PRONOUNCED DEAD Month Day Year Hour July 20, 1972 3:15 A. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1202 | | C. CITY OR TOWN Baltimore | |
| 6. SEX Male | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH | | 10. AGE (In years last birthday) 36 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | ADDRESS | |
| 19. 5-7-18 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | CAUSE OF DEATH Fatty metamorphosis of liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/2/72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 7-2-72 | |
| 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Andrew H. Hoston | |
| 25C. FUNERAL DIRECTOR | | ADDRESS | |

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

8-3-1972 - Completion of cause of death on a pending medical examiner death certificate
Rohald N. Kornblum, M.D. HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| C-206 | | 72 07178 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | X | | REG. NO. 72 07178 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>Utah Cox</i> | | | | 2. DATE AND HOUR OF DEATH <i>7-21-72</i> | | STATE OF MARYLAND-DEPT | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Anne Arundel</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Lincoln Memorial Nursing Home</i> | | | | | | C. CITY OR TOWN <i>Croonsville</i> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| <i>27 N. Carey St. Baltimore, Md 21209</i> | | | | | | E. STREET AND NUMBER <i>Croonsville State Hospital</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>Black</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>1898?</i> | 9. AGE (in years last birthday) <i>74?</i> | 10. Under 1 Yr. Months Days | | 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unknown</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i> | | 11. BIRTHPLACE (State or foreign country) <i>Unknown</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Unknown</i> | | | | | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Unknown</i> | | | | 16. SOCIAL SECURITY NO. <i>219-543023T</i> | | 17. INFORMANT ADDRESS | | | |
| 18. <i>412-41</i> CAUSE OF DEATH | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | (A) IMMEDIATE CAUSE <i>Cardio-Respiratory Collapse</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Aortic Stenosis & insufficiency</i> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (usually medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>3-14-</i> 19 <i>72</i> to <i>7-21-</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>7-21-</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>A. I. Baykaler, M.D.</i> | | | | Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>7-21-72</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>A. I. BAYKALER, M.D.</i> | | | | 23D. ADDRESS <i>301 Mc Mechen St. Balt. Md.</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <i>7-26-72</i> | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JUL 31 1972</i> | | 25B. NAME OF REGISTRAR <i>Lidney Horton</i> | | | | | | | |
| ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD | | | | | | | | | |

In Crownsville from 1956 - 3/14/72

OT

B-653

72 07179

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07179

REG. NO.

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) GEORGE BRYANT | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3018 E. Federal St. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 6 26 1972 9:22a M. | |
| 6. SEX male | | 7. RACE white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 802 | |
| 9. DATE OF BIRTH | | 10. AGE (In years lost birthday) 42 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT | | ADDRESS | |

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| MEDICAL CERTIFICATION | 19. 571.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH Fatty metamorphosis of liver | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| | ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |

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| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) yes |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6-26-72 EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | |

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|---|---|------------------------------------|--|
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE 7-28-72 | 24C. NAME of CEMETERY or CREMATORY | 24D. LOCATION (City, town or county) (State) |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | 25B. NAME OF REGISTRAR Adrian W. Weston | 25C. FUNERAL DIRECTOR | 25D. ADDRESS |

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCED

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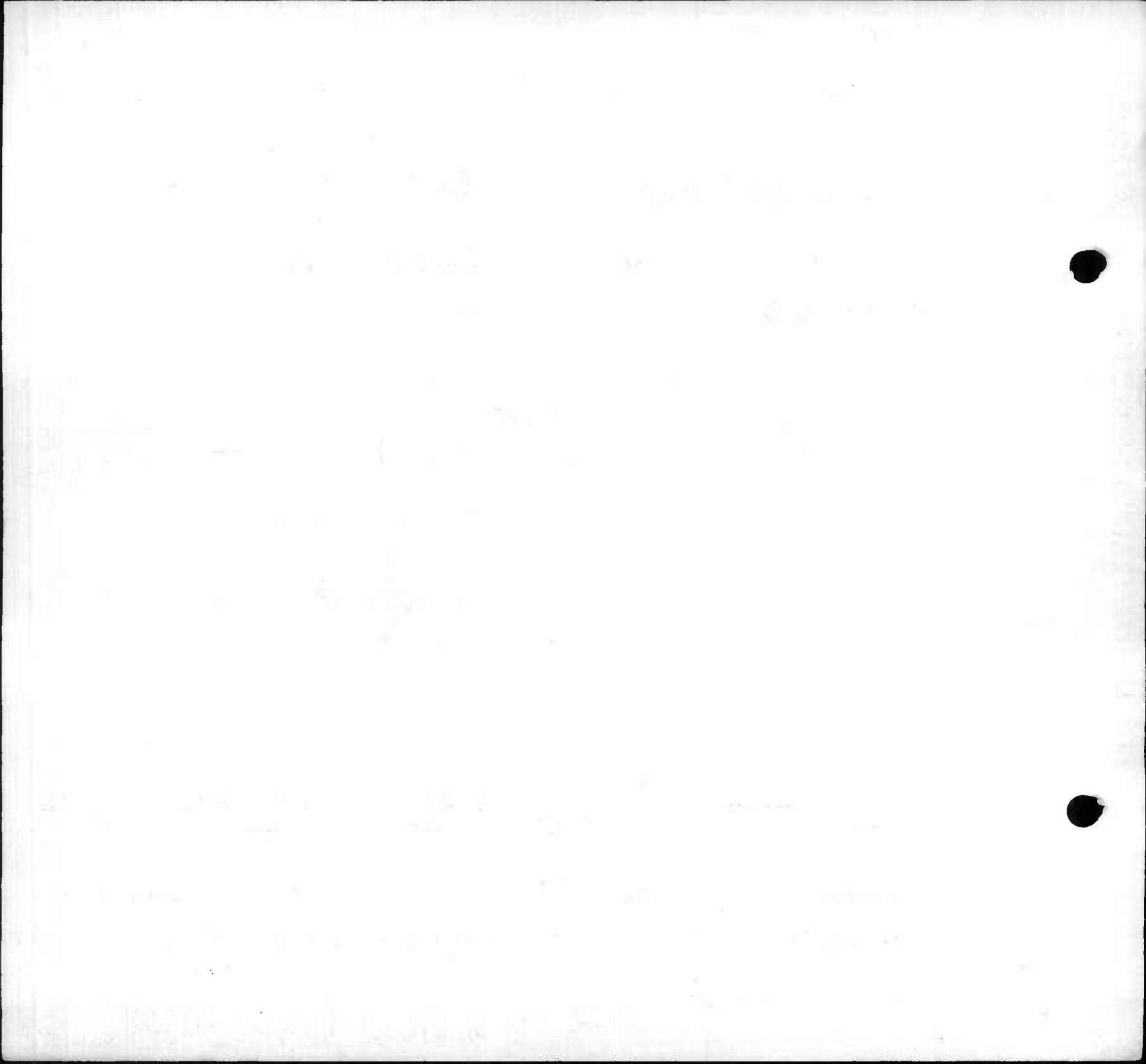
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case released by medical examiner 7/25/72

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

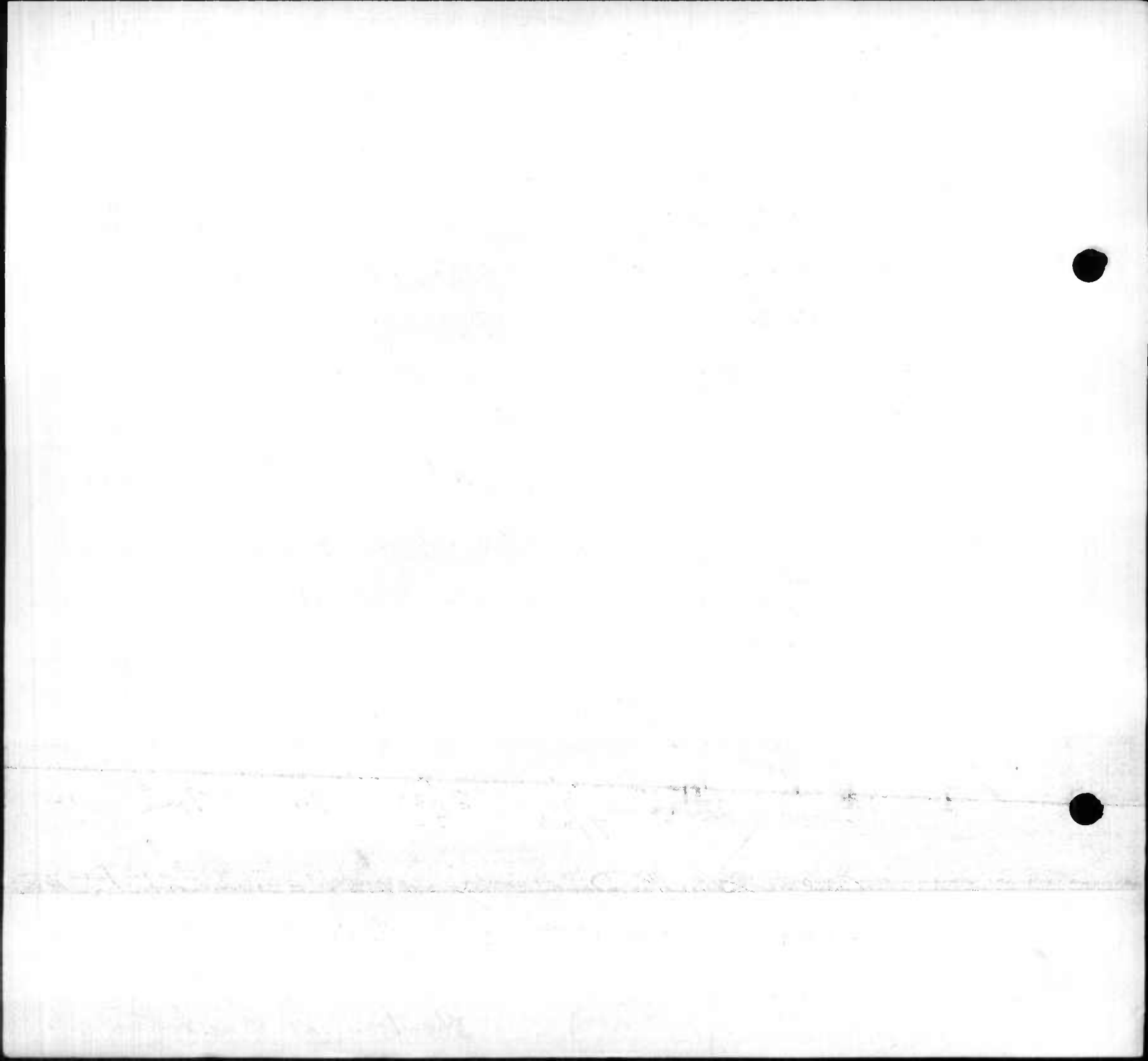
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| C-615 | | 72 07180 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07180 | |
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) HAL CARPENTER | | | | 2. DATE AND HOUR OF DEATH 7-21-72 10:07 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTIMORE | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GEN HOSP | | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER 1213 N. CALVERT ST - BALTIMORE #02 | | | | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-27-90 | 9. AGE (In years last birthday) 81 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) GA. | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 226014165 | | 17. INFORMANT ADDRESS | | | |
| 18. 18.5 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CARCINOMA of PROSTATE CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: with METASTASIS (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 years | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Hypertension | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-21 19 72 to 7-21 19 72 that (I) (we) last saw the deceased alive on 7-21 19 72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Melencio Ventura | | | | 23B. DATE SIGNED 7-22-72 | | 23C. PHYSICIAN'S NAME (Type) MELENCIO VENTURA | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 7-26-72 | | 24C. NAME OF CEMETERY or CREMATOR ANATOMY BOARD OF MARYLAND | | 24D. LOCATION (Specify, name of cemetery) | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Lidney Johnston | | 25C. SIGNATURE OF DIRECTOR UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHO | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| R-655 72 07181 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | 72 07181 REG. NO. | |
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) FRANCES RUHRMAN | | 2. DATE AND HOUR OF DEATH 7-23-72 10¹⁰ A^M | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bolton Hill Nursing Home 1400 John Street | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYland B. COUNTY 1701 C. CITY OR TOWN _____ D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 306 W. Franklin St. Congress Hotel | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/22/97 |
| 9. AGE (In years last birthday) 75 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Work | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Edwin Posey | | 14. MOTHER'S MAIDEN NAME Gray | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 562-36-0653 | |
| 17. INFORMANT | | ADDRESS | |
| 18. CAUSE OF DEATH 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF: (B) arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION 6/30 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/30 1972 to 7/23 1972 that (I) (we) last saw the deceased alive on 7/23 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE ae | | 23B. DATE SIGNED 7/26/72 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. L. A. M. H. M. | | 23D. ADDRESS 26 READ ST BALTIMORE MD | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) 7-26-72 | | 24B. DATE 7-26-72 | |
| 24C. NAME OF CEMETERY or CREMATOR ANATOMY BOARD OF MARYLAND | | 24D. LOCATION (City, town, or county) (State) UNIVERSITY MEDICAL SCHOOL | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Lidney H. H. H. | |
| 25C. FUNERAL DIRECTOR MORTUARY SERVICE | | 25D. ADDRESS BCHD | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07182

BIRTH NO.

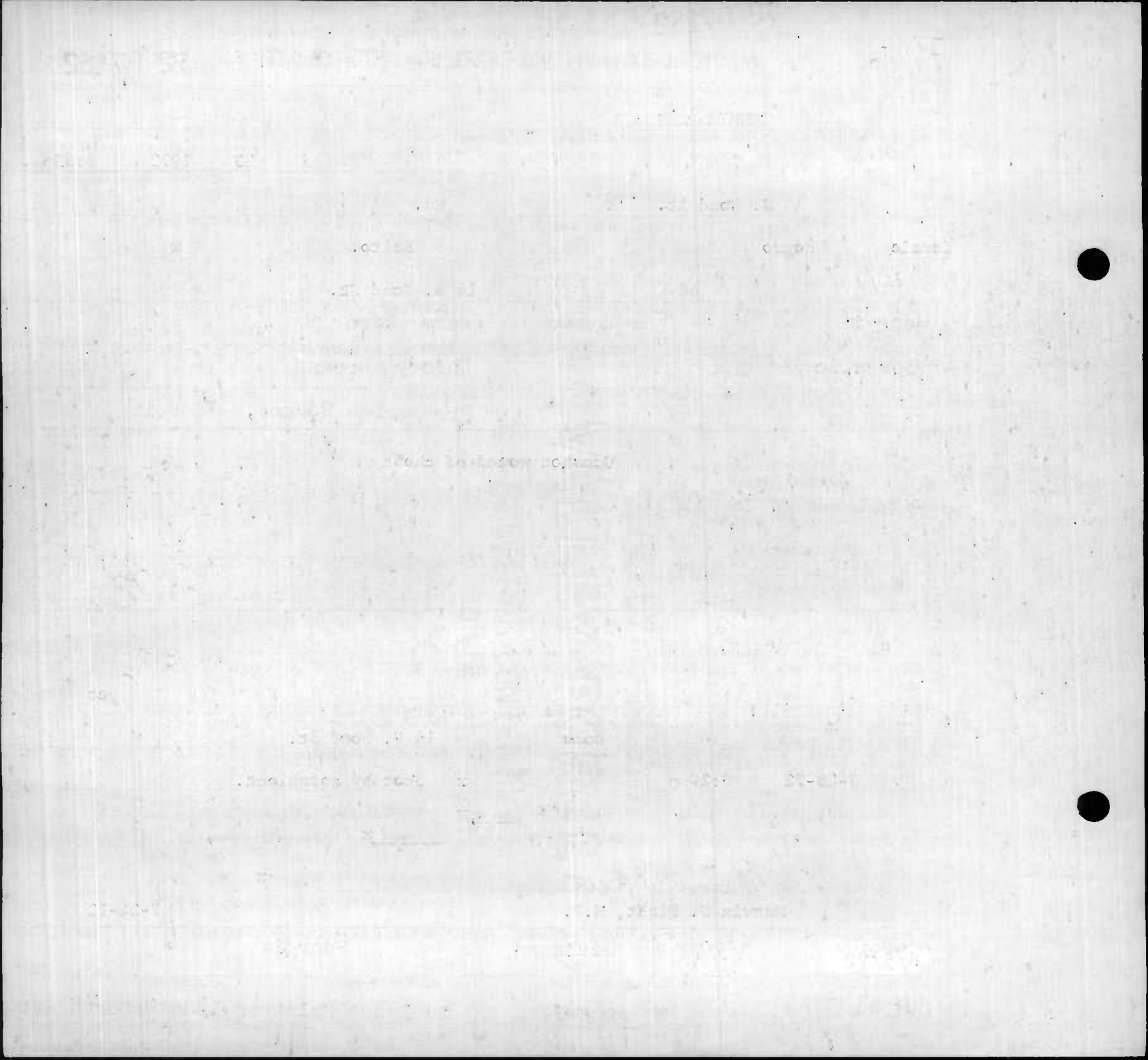
| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) TOMMIE ROBINSON | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 14 S. Bond St. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 23 1972 8:35 PM | |
| 6. SEX female | | 7. RACE negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 301 | |
| 9. DATE OF BIRTH 10/16/24 | | 10. AGE (In years, last birthday) 47 | |
| 11. BIRTHPLACE (State or foreign country) Georgia | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Jesse Ward | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | |
| 15. MOTHER'S MAIDEN NAME Daisey Brown | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT Mrs Martha Hodges, Georgia | |

| | | | | | |
|---|--|--|--|--|--|
| 19. E 9654 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | CAUSE OF DEATH Gunshot wound of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |

| | | | | | |
|--|--|--|--|---|--|
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 14 S. Bond St. 301 | |
| 22D. TIME OF INJURY (APPROX.) 7-23-72 8:20 p.m. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Shot by assailant. | |

| | | | | | |
|--|--|--|--|--|--|
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-24-72 | | | | | |
|--|--|--|--|--|--|

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|---|--|--|--|---|--|---|--|
| 24A. BURIAL CREMATION, RE: BURIAL | | 24B. DATE 8/5/72 | | 24C. NAME OF CEMETERY or CREMATORY Richmond | | 24D. LOCATION (City, town, or county) (State) Georgia | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Adolphus Halstead | | 25C. FUNERAL DIRECTOR Adolphus Halstead | | ADDRESS 1206 W 14th Ave | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07183

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Richard B. Peace | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 7 Day 24 Year 72 Hour M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OF LOCATION) Maryland General Hospital | | 3. DATE PRONOUNCED DEAD Month 7 Day 24 Year 72 Hour 7:25 P. | |
| 6. SEX male | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 7. RACE Negro | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 70 | | 10. AGE (In years last birthday) 70 | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 14B. KIND OF BUSINESS OR INDUSTRY R R | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. 217-09-4369 | |
| 18. INFORMANT Mrs Ruth Seward | | ADDRESS 35 Barker Ave, N | |

| | | | |
|--|--|--|--|
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |

| | | | | | |
|--|--|--|--|--|--|
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) no | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |

23. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: *Peter Lipkovic* M.D.
EXAMINER'S NAME (Type): **Peter Lipkovic, M.D.**

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: **7/25/72**

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 7/29/72 | | 24C. NAME of CEMETERY or CREMATORY MT Auburn Cemetry | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md | |
| 25A. DATE REC'D BY HEALTH DEPT JUL 31 1972 | | 25B. NAME OF REGISTRAR <i>Audrey Whitford</i> | | 25C. FUNERAL DIRECTOR Adolphus Halstead | | ADDRESS 1206 W North A | |

8/472 - Correction form from funeral director.

ABC

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|---|--------------------------------------|---|--|
| V-521 | | 72 07184 | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>YOUNGBLOOD, ROY OSCAR</u> | | 2. DATE AND HOUR OF DEATH <u>7-29-72</u> <u>11:15</u> | |
| 3. PLACE IN <u>BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>WASH.</u> | | C. CITY OR TOWN <u>HAGERSTOWN</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>US PHS Hospital</u> <u>3100 Wyman Park Drive</u> | | E. STREET AND NUMBER <u>100 HARVARD ROAD</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>C</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-17-1931</u> | 9. AGE (In years last birthday) <u>37</u> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Installer</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>George Youngblood</u> | | 14. MOTHER'S MAIDEN NAME <u>KATHERINE Walters</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>1950-1954</u> | | 16. SOCIAL SECURITY NO. <u>215-269786</u> | | 17. INFORMANT <u>PATIENT CHART</u> | |
| 18. <u>201X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Bilateral Bronchopneumonia</u> <u>Pancytopenia</u> <u>Hodgkins Disease & Myelopoietic Syndrome</u> | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>6 months</u> <u>3 years</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>19 65</u> to <u>7-29</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>7-29</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Robert H. Kirschner MD</u> | | | | 23B. DATE SIGNED <u>7-25-72</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Robert H. KIRSCHNER, MD.</u> | | | | 23D. ADDRESS <u>US PHS Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>8-1-72</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>CEDAR LAWN</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>HAGERSTOWN MD.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 31 1972</u> | | 25B. NAME OF REGISTRAR <u>Audrey Harrison</u> | |
| 25C. FUNERAL DIRECTOR <u>NORMENT F. H. HAGERSTOWN MD</u> | | 25D. ADDRESS | | | |

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

OFFICE OF THE
DIRECTOR OF HEALTH

1871-82

A.M.

G-600

72 07185

STATE OF MARYLAND-DEMH
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07185

BIRTH NO.

REG. NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) HELEN GRAY | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1703 W. Lombard St. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 29 1972 9:15 a M. | |
| 6. SEX female | | 7. RACE white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1903 | |
| 9. DATE OF BIRTH 12-10-1910 | | 10. AGE (In years last birthday) 61 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13. FATHER'S NAME unknown | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | |
| 15. MOTHER'S MAIDEN NAME unknown | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | |
| 17. SOCIAL SECURITY NO. none | | 18. INFORMANT ADDRESS Mr. T. Kipwell 1710 W. Lombard St 21223 | |
| 19. 412.4 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 8-1-72 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) no | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. DATE SIGNED 7-29-72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 8-1-72 | |
| 24C. NAME OF CEMETERY or CREMATORY GLEN HAVEN | | 24D. LOCATION (City, town, or county) (State) GLENBURNIE MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Sidney Johnston | |
| 25C. FUNERAL DIRECTOR GEO. L. SCHWAB INC | | ADDRESS 2101 FRED'K AVE BALTO. MD. 21223 | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07186

BIRTH NO.

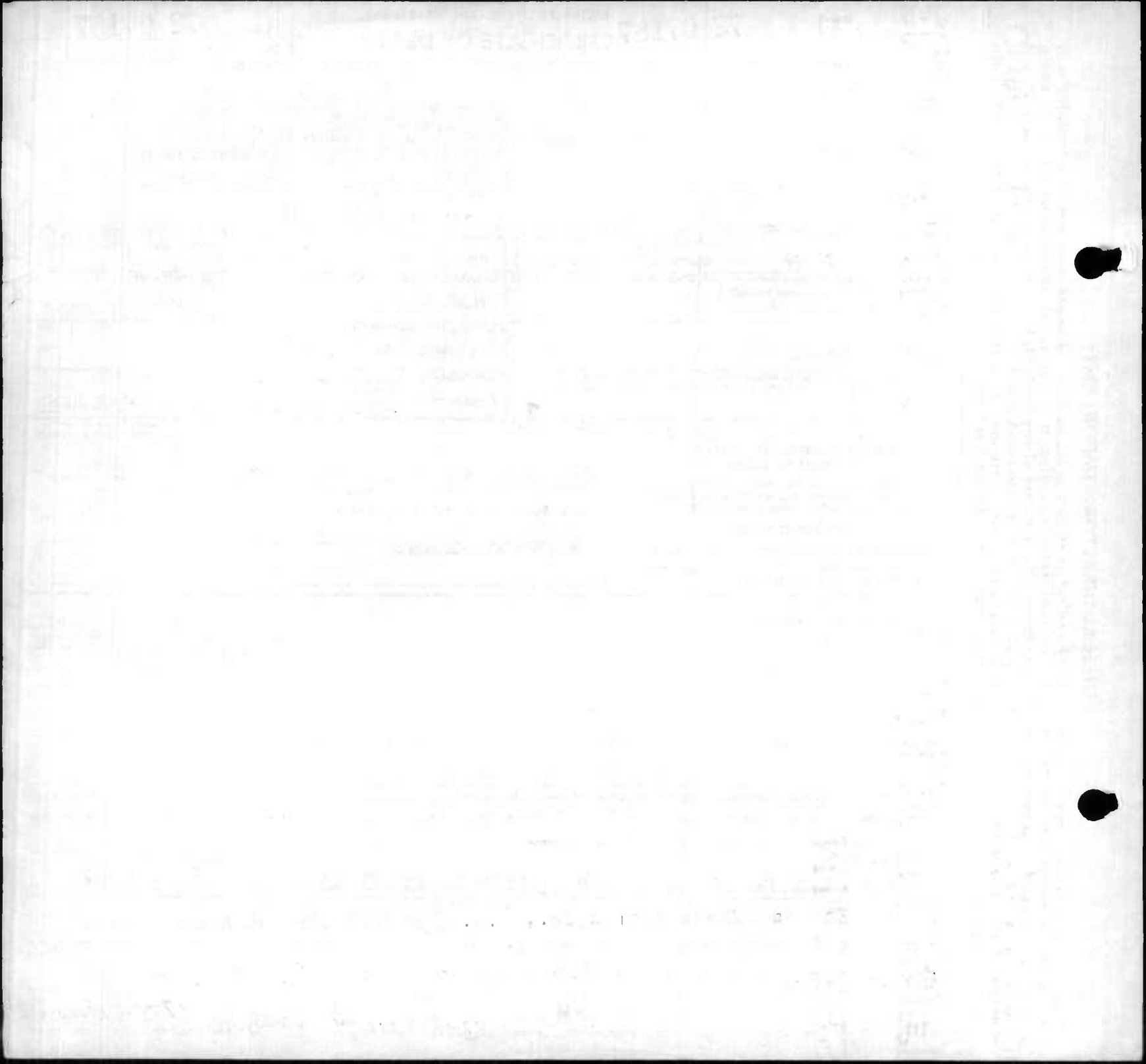
REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Elzie Wood | | | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 7 27 72 10:15 P.M. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4026 Cedardale Avenue | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 27 72 10:15 P.M. | | | |
| 6. SEX Male | | | | 7. RACE LNegro | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 9. DATE OF BIRTH May 9, 1920 | | | | 10. AGE (In years last birthday) 52 | | 11. BIRTHPLACE (State or foreign country) South Carolina | |
| 12. CITIZEN OF U.S.A. | | | | 13. FATHER'S NAME Charlie Wood | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofer | |
| 15. MOTHER'S MAIDEN NAME Laura Jeffers | | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 17. SOCIAL SECURITY NO. 251-01-9201 | |
| 18. INFORMANT Louise Wood Carver | | | | 19. ADDRESS 722 Glenwood Ave. | | | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20A. DATE OF OPERATION 7-27-72 | | | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House | | | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 4026 Cedardale Avenue | | | | 22D. TIME (Month) (Day) (Year) (Hour) (P.M.) OF INJURY (APPROX.) 7 27 72 10:00 P. | | | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 22F. HOW DID INJURY OCCUR? Shot during argument | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE W P Mulloy M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) William P. Mulloy, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7-28-72 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-31-72 | | 24C. NAME of CEMETERY or CREMATORY Arbutus Memorial | | 24D. LOCATION (City, town, or county) (State) Arbutus, Balto. Co., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Andrew W. Jones | | 25C. FUNERAL DIRECTOR Marshall W. Jones, Jr. | | ADDRESS 1735 Harford Ave. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07187 | |
|---|-------------------------|---|---|---|---|
| 7-520 | | | | 72 07187 | |
| BIRTH NO. | | | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) Alfred R. Thomas | | | 2. DATE AND HOUR OF DEATH July 29, 1972 3:05 PM | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital | | | A. STATE Maryland | | |
| IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | | B. COUNTY Baltimore City | | |
| | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 301 N. Calhoun St | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 04/09/23 | 9. AGE (In years last birthday) 49 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) City Sanitation Worker | | | 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME William Thomas | | | 14. MOTHER'S MAIDEN NAME PEARL MA PULLEY | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 231 18 7591 | | 17. INFORMANT JESSE THOMAS (self) 4302 ADELLE TERRACE Apt. 202 |
| 18. 162111 | | | CAUSE OF DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | (A) IMMEDIATE CAUSE Respiratory arrest due to aspiration pneumonia and lung cancer (squamous cell cancer) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | 10 days |
| | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | 10 months |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from July 21 , 19 72 to July 29 , 19 72 that (1) (we) last saw the deceased alive on 2:30 PM July 29, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (We) (did) view the body after death. | | | | | |
| 23A. SIGNATURE Edward James Busick Jr. MD | | | | 23B. DATE SIGNED July 29, 1972 | |
| 23C. PHYSICIAN'S NAME (Type) EDWARD JAMES BUSICK JR., M.D. | | | | 23D. ADDRESS 1620 McElderry St Baltimore 21205 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal-Burial | | 24B. DATE 8/4/72 | | 24C. NAME OF CEMETERY OR CREMATORY OLIVE BRANCH Baptist | |
| 24D. LOCATION (City, town, or county) (State) WAKE FOREST, N.C. | | 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Frederick Harrison | |
| 25C. FUNERAL DIRECTOR Marshall W. Jones, Jr. | | ADDRESS 1735 HARFORD AVE. | | | |

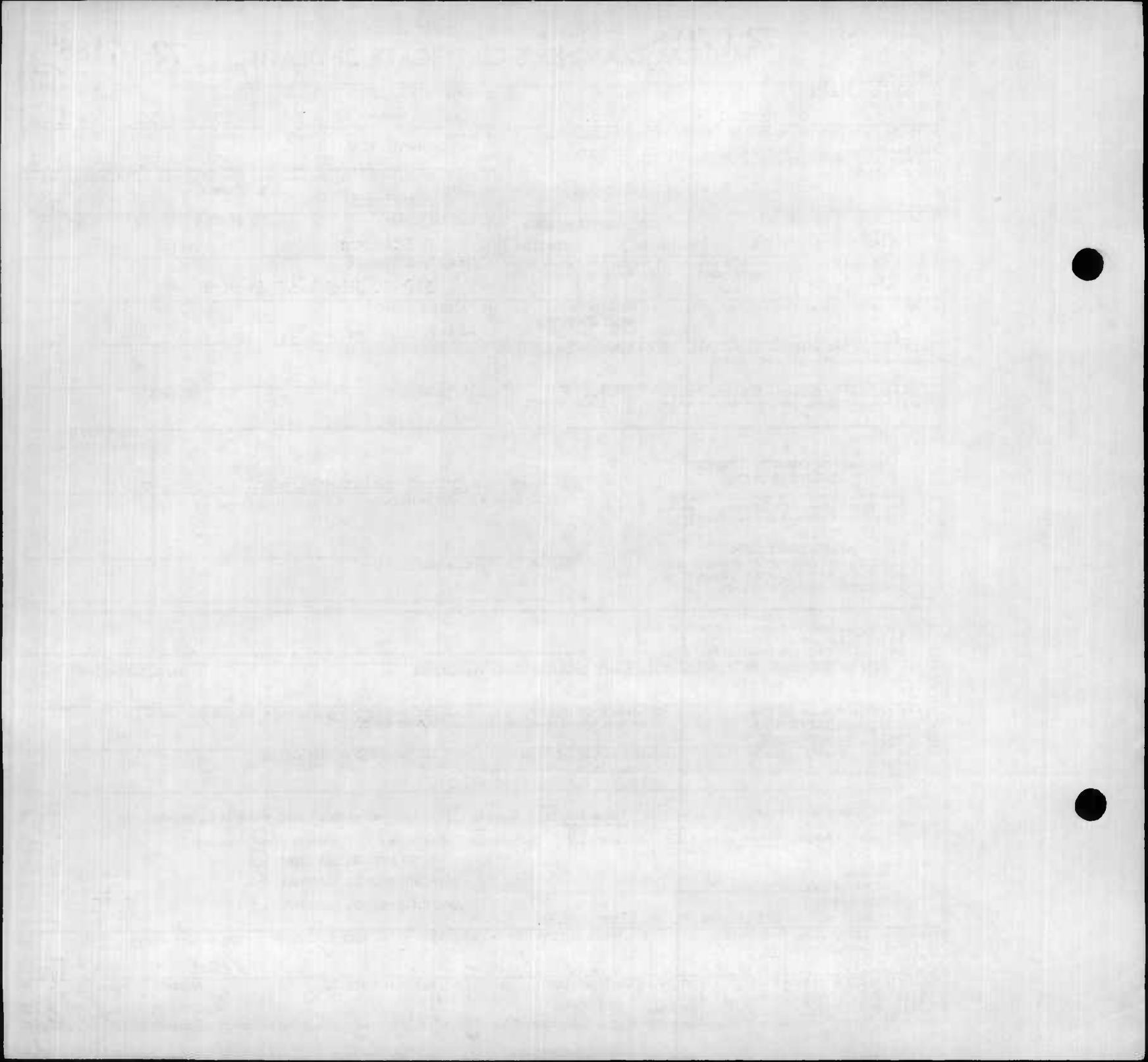


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

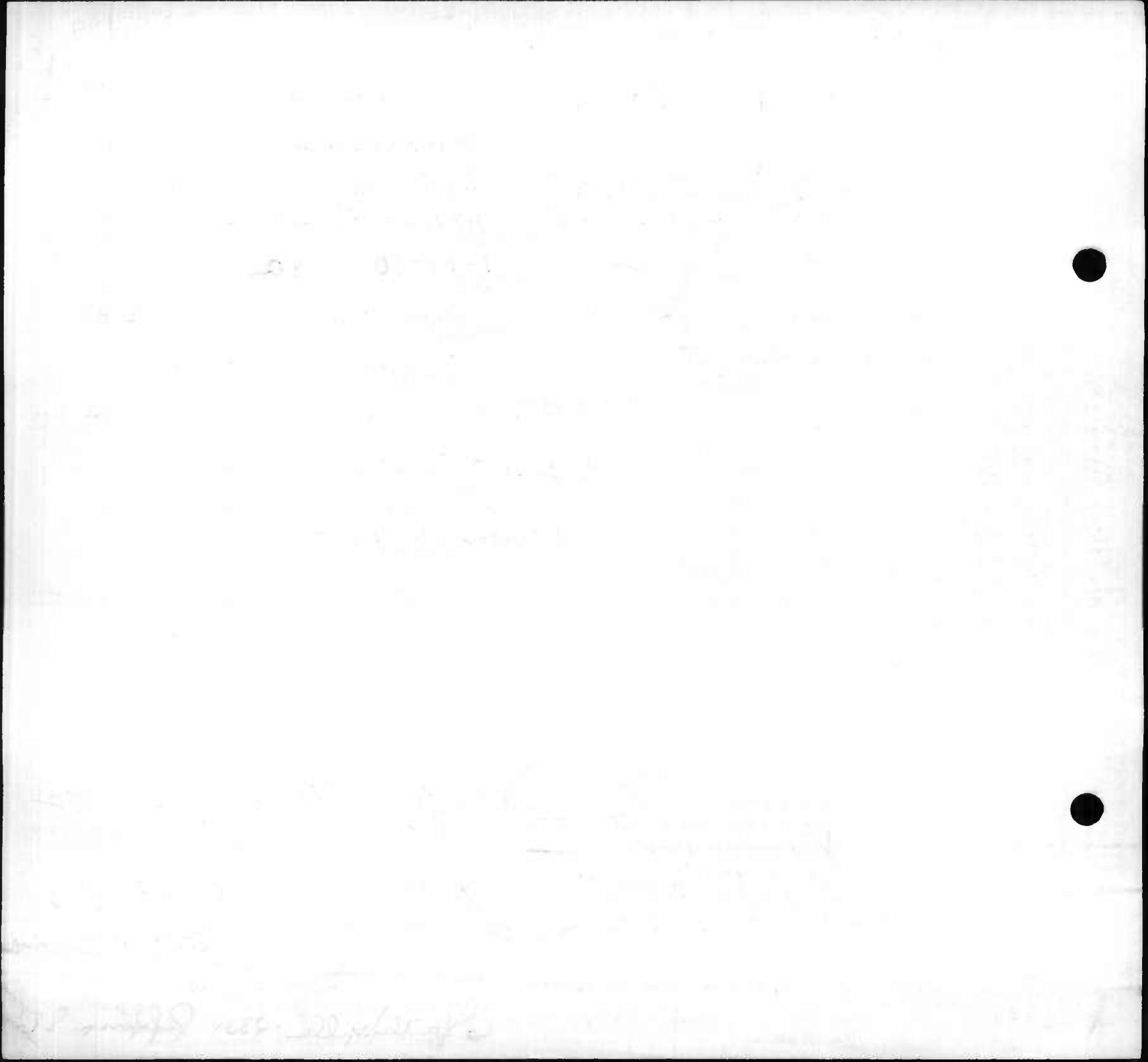
| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Robert H. Wolf, Sr. | | 2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 7 27 72 P. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 319 S. Highland Avenue | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 27 72 11:05 P. M. | |
| 6. SEX Male | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 5/24/1899 | | 10. AGE (In years lost birthday) 73 | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 14B. KIND OF BUSINESS OR INDUSTRY Platt Paper Corp | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 318-07-0588 | |
| 18. INFORMANT Mr. Russell A. Wolf | | ADDRESS | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.) Month Day Year Hour () () () () | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on inquiry <input type="checkbox"/> inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: William P. Mulloy, M.D. EXAMINER'S NAME (Type): William P. Mulloy, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 7-28-72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/31/72 | |
| 24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Sidney H. [unclear] | |
| 25C. FUNERAL DIRECTOR Joseph N. Zannone | | ADDRESS 263 S. [unclear] | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

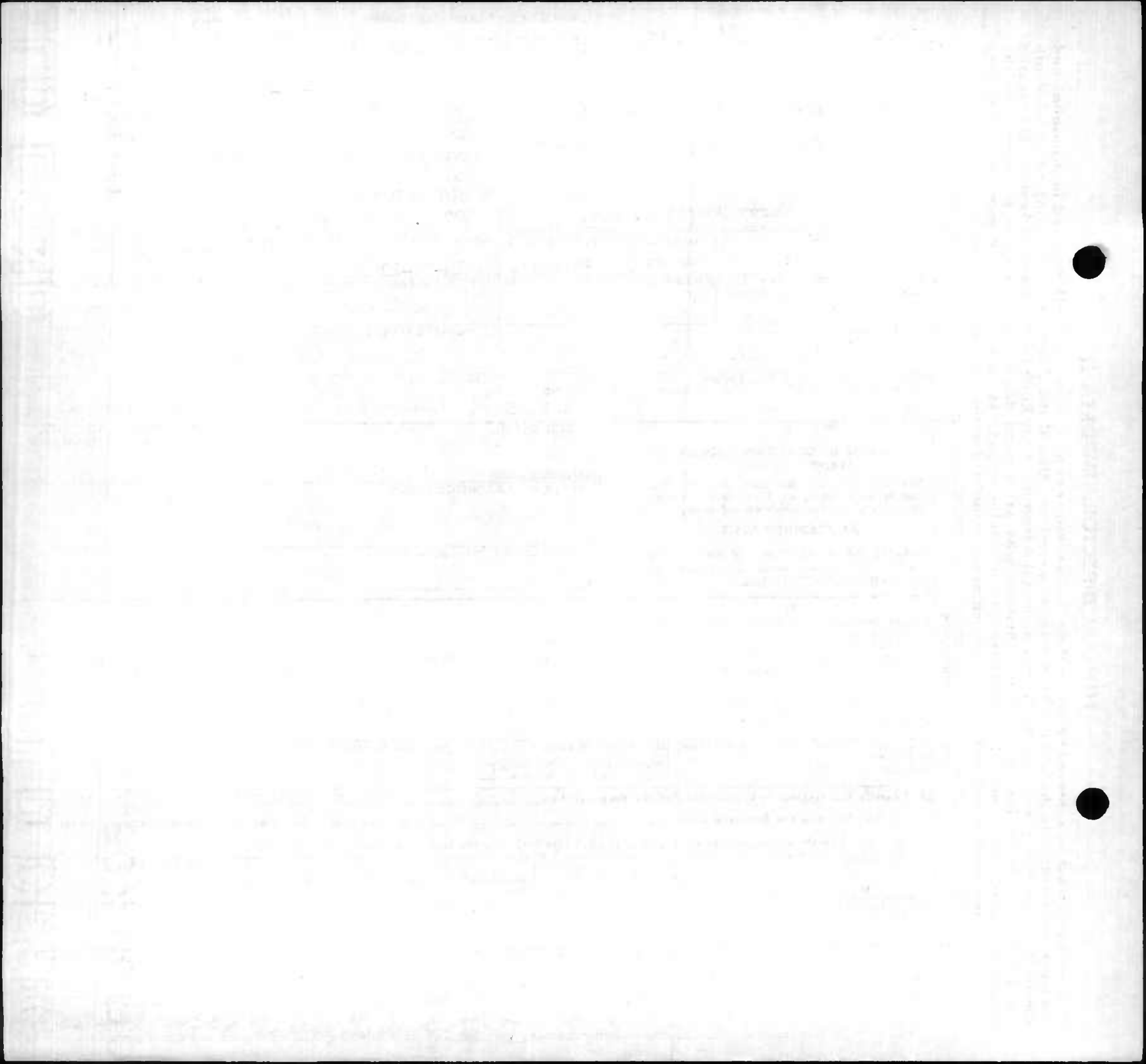
| | | | | | | | |
|---|---------|--|------------------|--|------------------------|--|-------------------------|
| X-400 | | 72 07189 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07189 | |
| BIRTH NO. | | 72 07189 | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) | | Josephine Kealey | | 2. DATE AND HOUR OF DEATH | | 7-28-72 6:45 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | A. STATE | | B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | Baltimore Maryland | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| 90 MT SINAI Nursing Home 4613 Park Heights Ave Baltimore, Md 21215 | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER | | 713 N. Montford Ave | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. UNDER 1 Yr. Months | 11. UNDER 24 Hrs. Days | 12. UNDER 24 Hrs. Hours |
| Female | W | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 1-17-90 | 80 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| SALES LADY | | BAKERY | | MARYLAND | | U.S.A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | | | |
| William Knight | | Virginia Garish | | | | | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | 219-12-9377 | | Mrs. Marion Paul | | 713 N. Montford Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE | | | | | |
| ANTECEDENT CAUSES | | DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) CHRONIC NEPHRITIS | | | | | |
| | | (C) | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 19 19 72 to July 28 19 72 | | | | | | | |
| that (I) (we) last saw the deceased alive on July 27 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | | | |
| Louis T. Lavy M.D. | | July 28 - 1972 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | | | |
| LOUIS T. LAVY M.D. | | 3502 W. Rogers Ave Baltimore Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | | 7/31/72 | | BALTO. NATIONAL CEM. | | BALTO., MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JUL 31 1972 | | Sidney H. Hooton | | Charles J. Hooton | | 2334 Siffert St | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07190 | |
|--|--|--|--|---|--|
| 72 07190 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. L-516 | | 1. NAME OF DECEASED (Type or Print) A. Jessie Lambert | | 2. DATE AND HOUR OF DEATH 7-28-72 12:30 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital, Inc. | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 601 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 407 N. Robinson St. #21221 | | |
| 5. SEX Female | | 6. RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRESSER | | 10B. KIND OF BUSINESS OR INDUSTRY CLOTHING IND. | | 8. DATE OF BIRTH 10-25-12 | |
| 13. FATHER'S NAME — MISTER | | 14. MOTHER'S MAIDEN NAME OLIVE CORBERT | | 9. AGE (In years last birthday) 59 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 212-07-3215 | | 17. INFORMANT Mr. Edward G. Lambert ADDRESS 407 N. Robinson St. | |
| 18. CAUSE OF DEATH | | | | | |
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary of the (B) DUE TO, OR AS A CONSEQUENCE OF: Lead of pancreas with obstruction (C) gallbladder, ascites and widespread metastases | | |
| MEDICAL CERTIFICATION | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNOERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 19 72 to 7-28 19 72 that (2) (we) last saw the deceased alive on 7-28 19 72 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above (4) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Thomas V. Whitten MD | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-1-72 | | 24C. NAME of CEMETERY or CREMATORY HOLLY HILLS Cem. | |
| 24D. LOCATION (City, town, or county) (State) BALTO., Md. | | 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | | |
| 25B. NAME OF REGISTRAR Sidney H. ... | | 25C. FUNERAL DIRECTOR Wentworth ... | | ADDRESS - 2334 Jefferson St | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>72 07191</u> | |
|---|----------------------|---|---|--|---|
| BIRTH NO. <u>H-652</u> <u>72 07191</u> | | | | STATE OF MARYLAND - DEPT | |
| 1. NAME OF DECEASED (Type or Print) <u>CORRINA HERRING</u> | | | 2. DATE AND HOUR OF DEATH <u>JULY 28, 1972</u> <u>2:50 A.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>8 MARYLAND GEN. HOSP.</u> <u>827 LINDEN AVE.</u> <u>BALTO., MD. 21201</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1301</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2427 LAKEVIEW AVE</u> | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>BLACK</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>APRIL 15, 1907</u> | 9. AGE (In years last birthday) <u>65</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COOK</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>SHEPHERD LANE</u> | | 11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | | |
| 13. FATHER'S NAME <u>SANDY AUSTIN</u> | | | 14. MOTHER'S MAIDEN NAME <u>FRANCES AUSTIN</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT (husband) <u>HARRY HERRING</u> ADDRESS <u>7427 LAKEVIEW AVE.</u> | |
| 18. <u>571.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Hepatic insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Hepatic cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>chronic alcoholism</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Cryptococcosis, med CHF, ASCUD.</u> | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month Day Year Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>June 16, 1972</u> to <u>July 26, 1972</u> that (I) (we) last saw the deceased alive on <u>July 28, 1972</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Maellari</u> MD DEGREE | | | 23B. DATE SIGNED <u>7/28/72</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>R.T. MACCARI</u> MD DEGREE | | | 23D. ADDRESS <u>MARYLAND GENERAL HOSP.</u> <u>827 LINDEN AVE., BALTO., MD.</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <u>8-1-72</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Lebanon Mem Park, Balto, Md</u> | |
| 24D. LOCATION (City, town or county) (State) | | 24E. FUNERAL DIRECTOR <u>Joseph F. H-1701-Lawrens</u> ADDRESS | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 31 1972</u> | | 25B. NAME OF REGISTRAR <u>Anthony Johnston</u> | | 25C. FUNERAL DIRECTOR <u>Joseph F. H-1701-Lawrens</u> | |

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07192

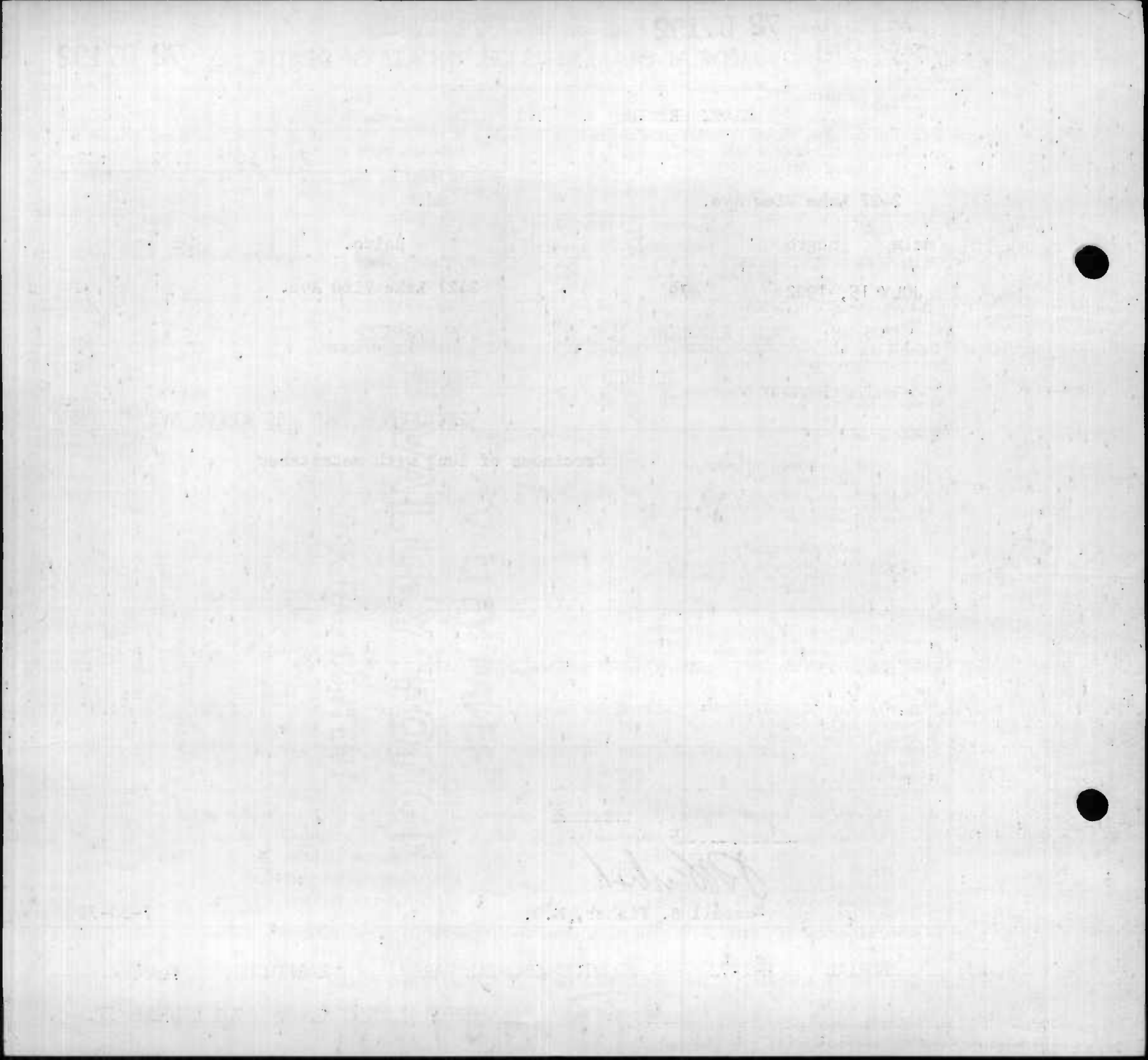
BIRTH NO.

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) HARRY HERRINE HERRING | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2427 Lake View Ave. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 30 1972 6:32a M. | |
| 6. SEX male | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 7. RACE negro | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH JULY 15, 1902 | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 10. AGE (In years lost birthday) 70 | | E. STREET AND NUMBER 2427 Lake View Ave. | |
| 11. BIRTHPLACE (State or foreign country) GARLAND, NORTH CAROLINA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 14B. KIND OF BUSINESS OR INDUSTRY RETIRED | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT REV. JOHN MOTLEY | | ADDRESS 455 ROMONA AVE MONTEREY CALIFORNIA | |

| | | |
|--|--|--|
| 19. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Carcinoma of lung with metastases | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | |

| | | | | |
|---|--|---|--|--|
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) no |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. M.D. EXAMINER'S NAME (Type) DATE SIGNED 7-30-72 | | | | |

| | | | | |
|---|--|---|--|---|
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 8-1-72 | 24C. NAME of CEMETERY or CREMATORY ARBUTUS MEMORIAL PARK | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Lidney | | 25C. FUNERAL DIRECTOR MORTON & DYETT F. H. 1701 LAURENS ST. |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|-------------------------|---|-------------------------------------|---|---|---|--|
| B-400 | | 72 07193 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07193 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) ALONZO BELL | | 2. DATE AND HOUR OF DEATH 7/26/72 11:45 P. | | STATE OF MARYLAND-DHMH | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL 33 | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE MARYLAND | | B. COUNTY BALTIMORE | |
| C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER 926 BROOKS LANE | | | |
| 5. SEX M | 6. RACE NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/23/30 | 9. AGE (In years last birthday) 41 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMAN | | 10B. KIND OF BUSINESS OR INDUSTRY SEAMAN | | 11. BIRTHPLACE (State or foreign country) ENFIELD, N. C. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME BELL STEVENSON | | | | 14. MOTHER'S MAIDEN NAME SMITH MATTIE | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO. | | 16. SOCIAL SECURITY NO. 227-30-3092 | | 17. INFORMANT SISTER | | ADDRESS 934 BROOKS LA. BALTO. | |
| 18. CAUSE OF DEATH 571.0 14 011.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEPATIC AND RENAL FAILURE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ALCOHOLIC HEPATITIS (B) DUE TO, OR AS A CONSEQUENCE OF: CHRONIC ALCOHOLISM (C) ? TBC | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ? | | | | | | | |
| 19A. DATE OF OPERATION 2-0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 0 | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/1/72 19 to 7/26/72 19 that (I) (we) lost saw the deceased alive on 7/26/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 22A. SIGNATURE Neill S. Hirst MD | | | | 22B. DATE SIGNED 7/26/72 | | | |
| 23C. PHYSICIAN'S NAME (Type) NEILL S. HIRST MD | | 23D. ADDRESS JOHNS HOPKINS HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 7-31-72 | | 24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem. Balto Md | | 24D. LOCATION (City, town, or county) (State) BALTO MD | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Dorothy Johnson | | 25C. FUNERAL DIRECTOR Yorktowne F.H. 1701 Laurens | | ADDRESS St | |

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Chicago, Ill. U.S.A.

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STATE OF MARYLAND-DHMH
BALTIMORE CITY HEALTH DEPARTMENT

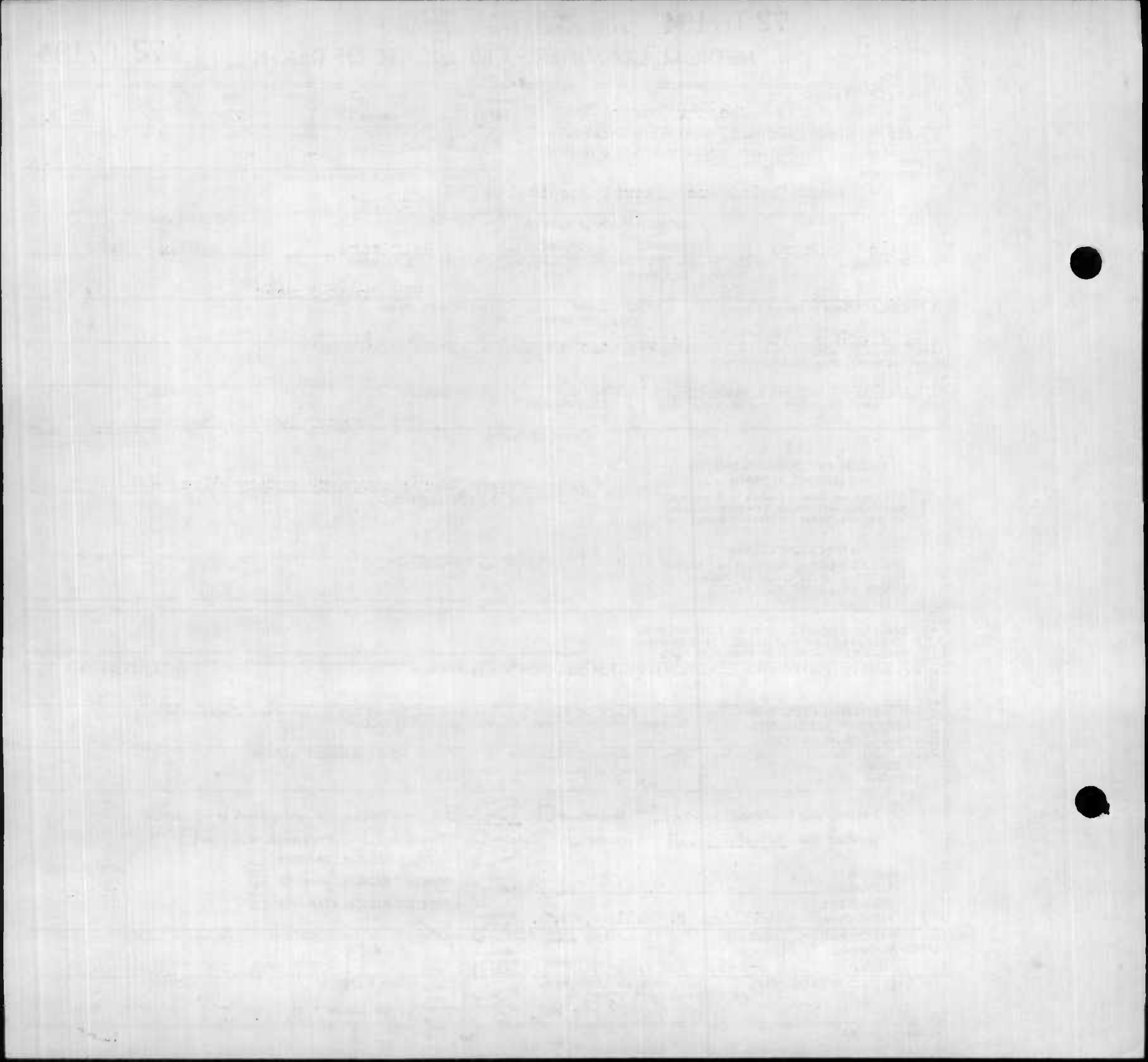
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07194

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Chester Howard | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 7 27 72 Hour: 5:20 P. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year 7 27 72 Hour: 5:20 P. M. | |
| 6. SEX Male | | 7. RACE Negro | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH JAN 11, 1911 | | 10. AGE (In years lost birthday) 61 | |
| 11. BIRTHPLACE (State or foreign country) GLOUCESTER VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOHN HOWARD | | 14. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Maryland B. COUNTY 1403 | |
| 15. MOTHER'S MAIDEN NAME CATHERINE HOWARD | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) BURNER | |
| 17. SOCIAL SECURITY NO. 212-13-7689 | | 18. INFORMANT DORIS HOWARD 2819 W. LANVALE ST | |
| 19. CAUSE OF DEATH 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | 20. DATE OF OPERATION 2 | |
| 21. AUTOPSY? (Yes or No) Yes | | 22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE W.P. Mulloy M.D. EXAMINER'S NAME (Type) William P. Mulloy, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-28-72 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 8-1-72 | |
| 24C. NAME OF CEMETERY or CREMATORY ARBUTUS MEMORIAL PARK | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Sidney L. Houston | |
| 25C. FUNERAL DIRECTOR MORTON & DYETT F. H. | | 25D. ADDRESS 1701 LAURENS ST | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07195

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) JESSE (JESSIE) R. JOHNSON | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4008 W. Franklin Street | | 3. DATE PRONOUNCED DEAD Month Day Year Hour July 27, 1972 6:55 A. | |
| 6. SEX Male | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2031 | |
| 9. DATE OF BIRTH JUNE 10, 1950 | | 10. AGE (In years lost birthday) 22 | |
| 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY ROMAN CO. INC. | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT MR. HERMAN JOHNSON | | ADDRESS 4008 W. FRANKLIN | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| (A) IMMEDIATE CAUSE Gunshot wound of abdomen DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____ | | | |
| 20A. DATE OF OPERATION 21 | | | |
| 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 21. AUTOPSY? (Yes or No) Yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Basement - 4008 W. Franklin Street | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) ? ? ? ? | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? ? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE <i>Charles S. Springate</i> M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 27, 1972 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 8-1-72 | |
| 24C. NAME OF CEMETERY or CREMATORY MT AUBURN CEMETERY | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR <i>Antony...</i> | |
| 25C. FUNERAL DIRECTOR ADDRESS 1701 LAURENS STREET 21217 | | 25D. FUNERAL HOME MORTON & DYETT FUNERAL HOMES, INC. | |

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101.05

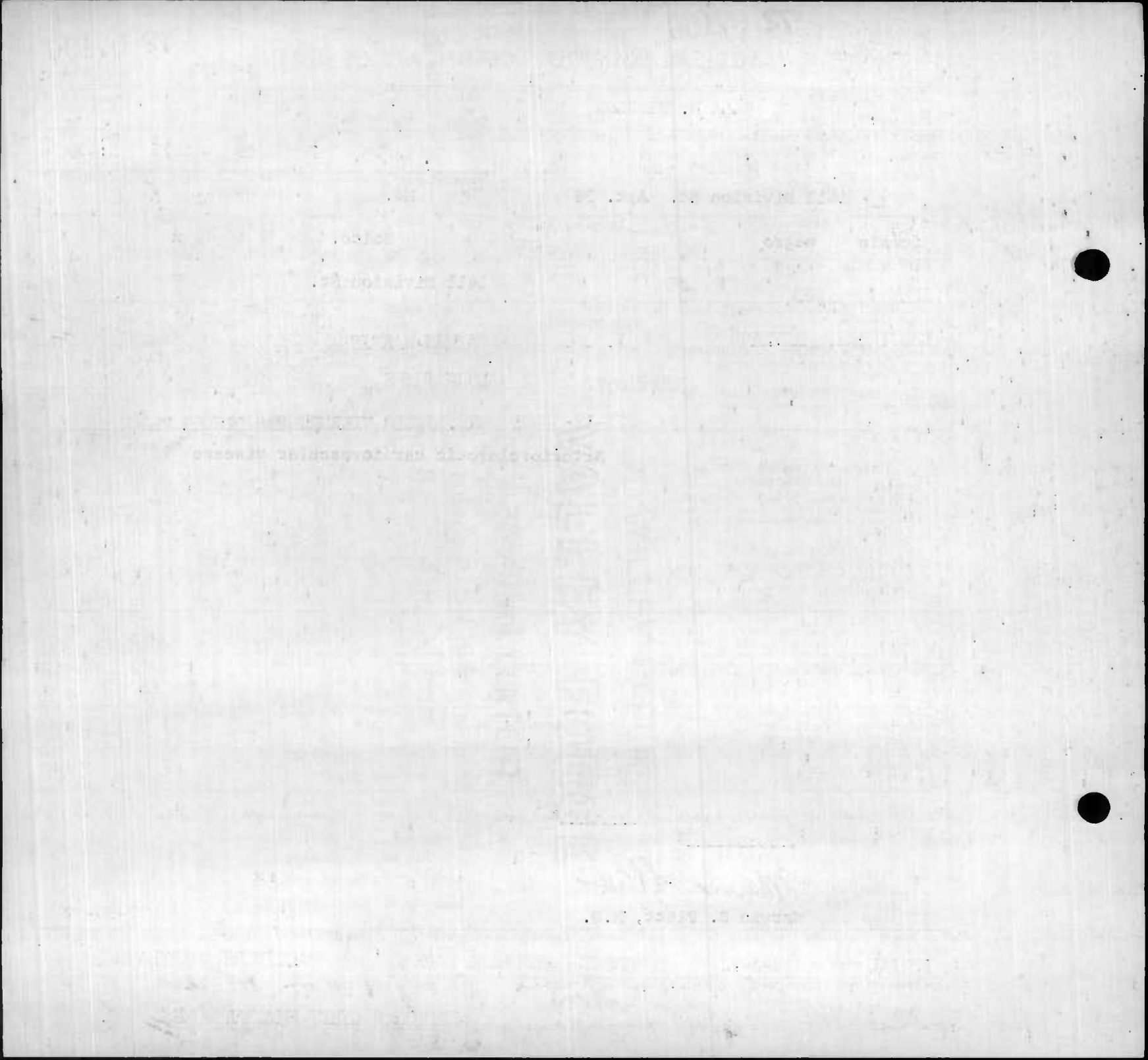
W-524

72 07196 STATE OF MARYLAND
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07196

| | | | |
|--|-------------------------|---|--|
| BIRTH NO. | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) ELLA M. WINSLOW | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1411 Division St. Apt. 38 | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 29 1972 1:45p | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 14-02 | | | |
| 6. SEX female | 7. RACE negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH JULY 4, 1903 | | 10. AGE (In years last birthday) 69 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME NATHAN HARRIS | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED | |
| 15. MOTHER'S MAIDEN NAME LORA JONES | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 17. SOCIAL SECURITY NO. 578-12-3800D | | 18. INFORMANT ADDRESS MRS. JULIA WILBURN 108 DIENER PLACE | |
| 19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (C) | |
| 20A. DATE OF OPERATION 7-12-72 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) no | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Marvin S. Platt M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Marvin S. Platt, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED 7-30-72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 8-3-72 | |
| 24C. NAME of CEMETERY or CREMATORY ARBUTUS MEMORIAL PARK | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Audrey Whitson | |
| 25C. FUNERAL DIRECTOR MORTON & DYETT FUNERAL HOMES, INC. | | ADDRESS | |



BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

JAMES L. JOHNSON JR.

2. DATE OF DEATH

Known ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

31 City Hospital

3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

M.

7

29

1972

3:21a

M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Md.

Balto.

5300

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

BALTO.

YES ☒NO ☐

6. SEX

male

7. RACE

negro

8. MARRIED

☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

NOV 30, 1922

10. AGE (In years last birthday)

49

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

704 Peach Orchard Rd.

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JAMES LEON JOHNSON, SR.

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SOCIAL SECURITY

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

HILDA DOW

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

YES

NOV 42 - 45

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

BESSIE M. JOHNSON 704 PEACH ORCHARD

19.

412.4

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Marvin S. Platt, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-29-72

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

BURIAL

8-2-72

CARVER MEMORIAL PARK

LAUREL, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JUL 31 1972

Sidney Isidor

1701 LAURENS STREET BALTO, MD.
MORTON & DYETT FUNERAL HOMES, INC.

1911

WILLIAM V. BOWEN

WILLIAM V. BOWEN

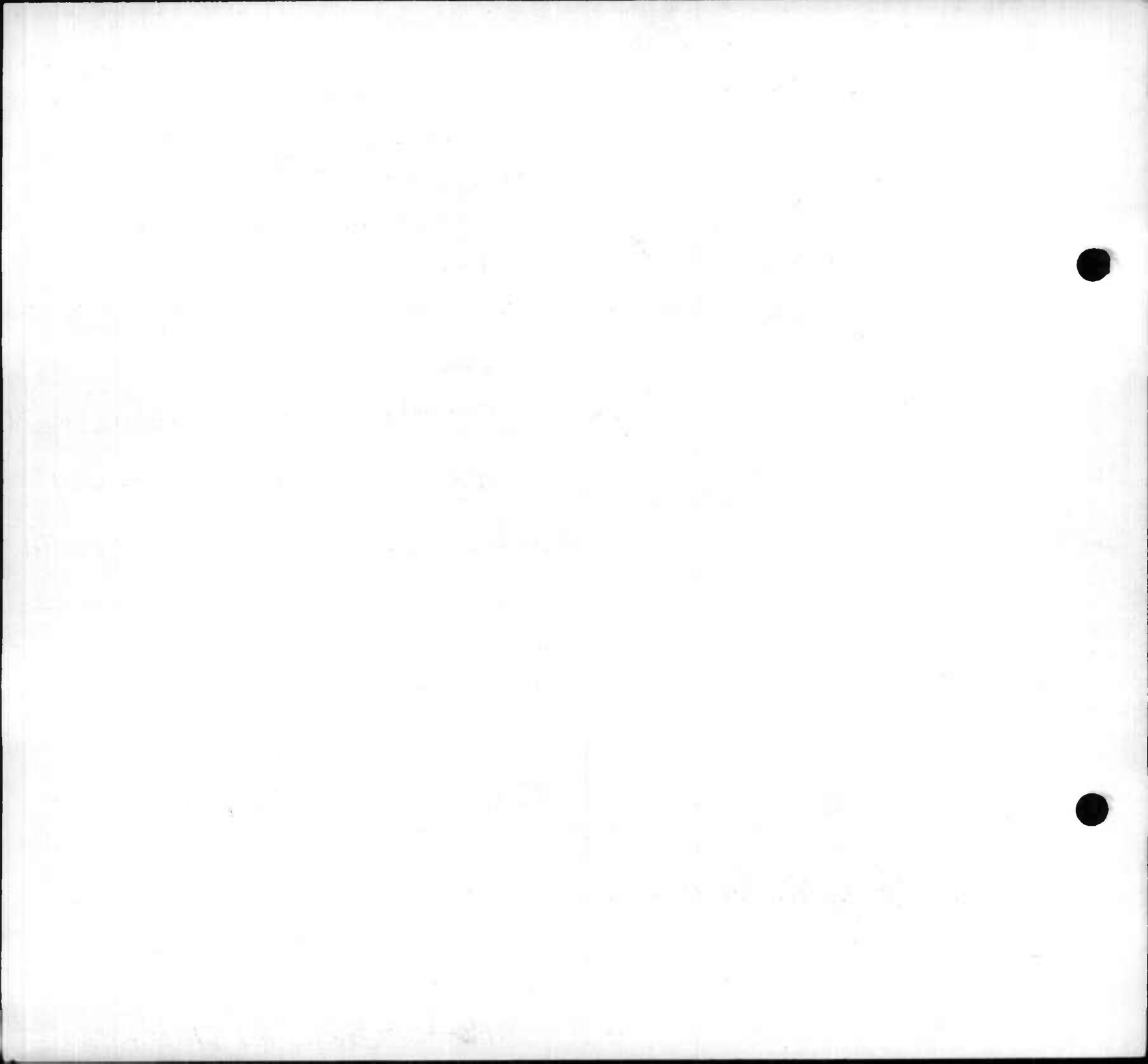
WILLIAM V. BOWEN

1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|-------------------------|---|------------------------------------|---|--|---|--|
| S-530 | | 72 07198 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07198 | |
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Smith, Kenneth</u> | | | | 2. DATE AND HOUR OF DEATH <u>29 July 1972</u> <u>7¹⁵</u> P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL OF BALTIMORE INC. 42</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE <u>MARYLAND</u> | | B. COUNTY <u>BALTIMORE</u> | |
| | | | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER <u>3501 Lucille Avenue</u> | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>BLACK</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-26-33</u> | 9. AGE (In years last birthday) <u>39</u> | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipping Clerk</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Dockside Warehouse</u> | | 11. BIRTHPLACE (State or foreign country) <u>Trinidad British West Indies</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>British West Indies</u> | |
| 13. FATHER'S NAME <u>UNK</u> | | | | 14. MOTHER'S MAIDEN NAME <u>UNK</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>UNK</u> | | 17. INFORMANT <u>Personal physician Harry M. WALEN M.D.</u> | | | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pseudomonas septicemia</u> | | | | <u>one day</u> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (b) <u>Amebic Abscess of Liver</u> <u>one month</u> | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>NONE KNOWN</u> | | | | | | | |
| 19A. DATE OF OPERATION <u>2-19-72</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Removal of packs from liver</u> | | 20A. AUTOPSY? (Yes or No) <u>yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>4 July</u> 19 <u>72</u> to <u>29 July</u> 19 <u>72</u> that (1) (we) last saw the deceased alive on <u>29 July</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Harry M. Waleen M.D.</u> | | | | 23B. DATE SIGNED <u>29 July 72</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>HARRY M. WALEN M.D.</u> | | | | 23D. ADDRESS <u>9115 Reisterstown Road Md.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>8-4-72</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Theodore F. H. Lott</u> | | 24D. LOCATION (City, town, or county) <u>Port - wa - Spring Garden B.W. Indies</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 31 1972</u> | | 25B. NAME OF REGISTRAR <u>Anthony...</u> | | 25C. FUNERAL DIRECTOR <u>Mortuaria Byett F.H. 1701 - Laurens St.</u> | | | |



72 07199 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07199

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John S. Wilson

2. DATE
OF
DEATHKnown ☒
Estimated ☐Month
7Day
24Year
72

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
OR INSTITUTION ADDRESS OR LOCATION)

1314 N. Central Avenue

3. DATE
PRONOUNCED DEADMonth
7Day
24Year
72Hour
1:45 p.

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Md.

B. COUNTY

909

6. SEX

male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

10. AGE (In years
last birthday)
59If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1314 N. Central Avenue

11. BIRTHPLACE (State or foreign country)

Norfolk Va.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Wilson

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Virginia Chatman

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

17. SOCIAL
SECURITY NO.

103-10-1424

18. INFORMANT

Fannie M. Lewis 2401 St. Steven Apt 3C

ADDRESS

19.

57181

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Fatty metamorphosis of liver

(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Arteriosclerotic cardiovascular disease

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes - partial

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/25/72

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7/31/72

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn

24D. LOCATION

(City, town or county)

Balto. Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 31 1972

25B. NAME OF REGISTRAR

Sidney H. Houston

25C. FUNERAL DIRECTOR

Joseph E. Lock

ADDRESS

1304 N. Central Ave

• 0. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840.

1

72 07200

STATE OF MARYLAND-DEMH
BALTIMORE CITY HEALTH DEPARTMENT

72 07200

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | | | |
|---|-------------------------|--|---|---|---|
| 1. NAME OF DECEASED (Type or Print) TYRONE M. MOORE | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> July 22, 1972 | | M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1328 E. Fayette | | 3. DATE PRONOUNCED DEAD Month Day Year July 22, 1972 | | Hour 11:30 P | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 501 | | | | | |
| 6. SEX Male | 7. RACE Negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH June 8, 1951 | | 10. AGE (In years last birthday) 21 | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME James Moore | | E. STREET AND NUMBER 1328 Fayette (east) | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 15. MOTHER'S MAIDEN NAME Constance Martin | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes | | 17. SOCIAL SECURITY NO. 219-52-5285 | | 18. INFORMANT ADDRESS Mrs. Constance Moore 2924 Arunah Ave | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (A) IMMEDIATE CAUSE Intravenous narcotism DUE TO, OR AS A CONSEQUENCE OF: complicating bronchopneumonia (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) Yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-23-72 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-27-72 | | 24C. NAME OF CEMETERY or CREMATORY Cedar Hill | |
| 24D. LOCATION (City, town, or county) (State) A.A.Co., Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Sidney [Signature] | | 25C. FUNERAL DIRECTOR ADDRESS Arlington S. Phillips 1727 N. Monroe Street | |

9-15-1972 - Completion of cause of death on a pending medical examiner death certificate
R. Fisher, M.D. HRS

H-160

72 07201

BALTIMORE CITY HEALTH DEPARTMENT

72 07201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND-DEPT. REG. NO.

BIRTH NO.

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) CLIFTON HOOPER | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) front of 1013 N. Appleton St. | | 3. DATE PRONOUNCED DEAD Month Day Year 7 28 1972 | |
| 6. SEX male | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 7. RACE negro | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 8-29-32 | | 10. AGE (In years lost birthday) 38 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Va. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman | | 13. FATHER'S NAME Pymous Hooper | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 15. MOTHER'S MAIDEN NAME Esther Strange | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT ADDRESS Ollie Beale sister 2013 Baker St. | |
| 19. E966 IX DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | CAUSE OF DEATH Stabwound of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street | |
| 22D. TIME OF INJURY (APPROX.) 7-28-72 9:55 p m. | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1013 N. Appleton St. | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Stabbed during altercation. | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-29-72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-2-72 | |
| 24C. NAME OF CEMETERY or CREMATORY Church Cem | | 24D. LOCATION (City, town, or county) (State) Northumberland Co., Va/ | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Sidney W. Horton | |
| 25C. FUNERAL DIRECTOR V. Bailey | | ADDRESS Kelson F.H. 1348 Calhoun St. | |

UNITED STATES

DEPARTMENT OF JUSTICE

MEMORANDUM

TO :

FROM :

SUBJECT :

RE :

DATE :

BY :

FOR :

FILE :

APPROVED :

SPECIAL AGENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|---|------------------------------------|---|---|
| 72 07202 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07202 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) <u>Haddie Cutts</u> | | 2. DATE AND HOUR OF DEATH <u>7-29-72</u> <u>1 33 A</u> M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1701</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hospital</u> <u>883 Linden Ave</u> <u>Baltimore, Md.</u> | | C. CITY OR TOWN <u>Balto.</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <u>501 Pennsylvania Ave.</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>6-13-09</u> | 9. AGE (In years last birthday) <u>63</u> | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>North Carolina</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Kelly Cutts</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Johnsie Lake</u> ADDRESS <u>5511 Chalgrove Ave.</u> | |
| 18. <u>45101</u> CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Pulmonary Embolism</u> | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <u>Thrombophlebitis, Right Leg</u> DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) _____ | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, home, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7/18/72</u> 19 to <u>7/29/72</u> 19 that (I) (we) last saw the deceased alive on <u>7/29/72</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Ronald H. H. H.</u> | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| 24D. LOCATION (City, town, or county) (State) | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| 25D. ADDRESS | | | | | |

22

10-1

411



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 72 07203 |
|---|---------------------|--|------------------------------------|---|
| BIRTH NO. 72 07203 | | 1. NAME OF DECEASED (Type or Print) GALE THEOLA | | |
| 2. DATE AND HOUR OF DEATH 7-28-72 12-40 A.M. | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2037 | | FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital of Maryland 46 | | |
| C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| E. STREET AND NUMBER 410 N. DENISON STREET | | | | |
| 5. SEX F | 6. RACE N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-18-24 | 9. AGE (In years last birthday) 48 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Daniel Lunn | | |
| 14. MOTHER'S MAIDEN NAME Charlotte | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service no | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Charles Raymond Scott same | | |
| 18. CAUSE OF DEATH 25091 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, (A) IMMEDIATE CAUSE F-U-O. (B) Diabetes, Hypertension and (C) Dehydration | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 7-20-72 19 to 7-28-1972 that (I) (we) last saw the deceased alive on 7-28-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE J. H. Siddiqui M.D. | | 23B. DATE SIGNED 7-28-72 | | 23C. PHYSICIAN'S NAME (Type) J. H. Siddiqui M.D. |
| 23D. ADDRESS | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-1-72 | | 24C. NAME OF CEMETERY or CREMATORY Church Com. |
| 24D. LOCATION Timmersville, S.C. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Shirley | | 25C. FUNERAL DIRECTOR V. Bailey 1348 Calhoun Street |

10-11-12

J-520

72 07204

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07204

BIRTH NO.

REG. NO.

1. NAME OF DECEASED
(Type or Print)

Pauline Jones

2. DATE
OF
DEATHKnown ☒ Estimated ☐Month
Day
Year7
27
72Hour
Minute
Second

3:13 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

3934 Park Heights Avenue

3. DATE
PRONOUNCED DEADMonth
Day
Year7
27
72Hour
Minute
Second

3:13 P. M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

1512

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

1-13-20

10. AGE (In years
last birthday)

52

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3934 Park Heights Avenue

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Leo McCray

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Goldie

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Albert Jones

same

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular
DUE TO, OR AS A CONSEQUENCE OF: disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

William P. Mulloy, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-28-72

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-31-72

24C. NAME of CEMETERY or CREMATORY

Church Cem.

24D. LOCATION (City, town, or county) (State)

Baeford, N.C.

25A. DATE REC'D BY HEALTH DEPT.

JUL 31 1972

25B. NAME OF REGISTRAR

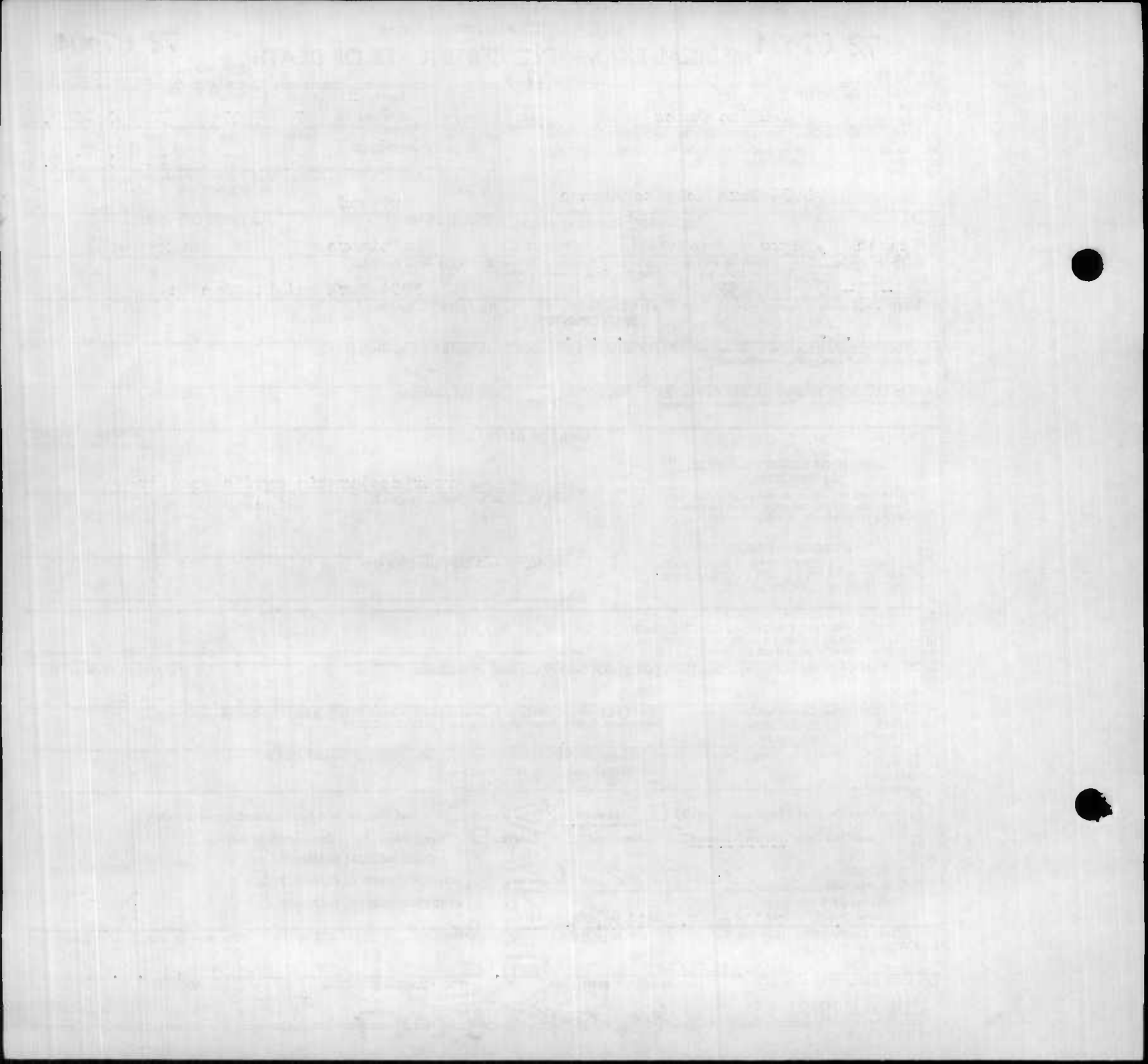
Sidney F. Bailey

25C. FUNERAL DIRECTOR

Kelson F.H.

ADDRESS

1348 Calhoun Street



72 07205

72 07205

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND - DEPT. OF HEALTH

BIRTH NO.

| | | | |
|--|-------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print) Ada Glover | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 7 25 72 M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2830 W. Baker Street | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 25 72 9:15 a. M. | |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1506 | | | |
| 6. SEX female | 7. RACE Negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 9. DATE OF BIRTH 2-8-16 | | 10. AGE (In years last birthday) 56 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 15. MOTHER'S MAIDEN NAME Catherine Gaither | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 17. SOCIAL SECURITY NO. 213098289 | |
| 18. INFORMANT Ruchell Reed son | | ADDRESS 4012 Franklin St. | |
| 19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CAUSATION LAST. | | CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 20A. DATE OF OPERATION 7-29-72 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D. DATE SIGNED 7/25/72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-29-72 | |
| 24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem. | | 24D. LOCATION (City, town, or county) (State) Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Frederick W. Houston | |
| 25C. FUNERAL DIRECTOR Kelson F.H. | | ADDRESS 1348 Calhoun Street | |

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Section 1

Section 2

Section 3

Section 4

Section 5

Section 6

Section 7

F-432

72 07206

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07206

STATE OF MARYLAND-DELMH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Harry Fields

2. DATE OF DEATH
Known ☒ Month Day Year Hour
Estimated ☐ 7 28 72 8:15 A. M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

2312 Avalon Avenue

3. DATE PRONOUNCED DEAD
Month Day Year Hour
7 28 72 8:15 A. M.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 1304

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

9-1-05

10. AGE (in years
lost birthday)

66

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2312 Avalon Avenue

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Nelson Fields

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Roda

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL SECURITY NO.

207-09-4899A

18. INFORMANT

Elmira Fields

ADDRESS

same

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular
DUE TO, OR AS A CONSEQUENCE OF: disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

William P. Mulloy, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-28-72

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8-1-72

24C. NAME of CEMETERY or CREMATORY

Church Cem.

24D. LOCATION (City, town, or county) (State)

Rawlings, Va.

25A. DATE REC'D BY HEALTH DEPT.

JUL 31 1972

25B. NAME OF REGISTRAR

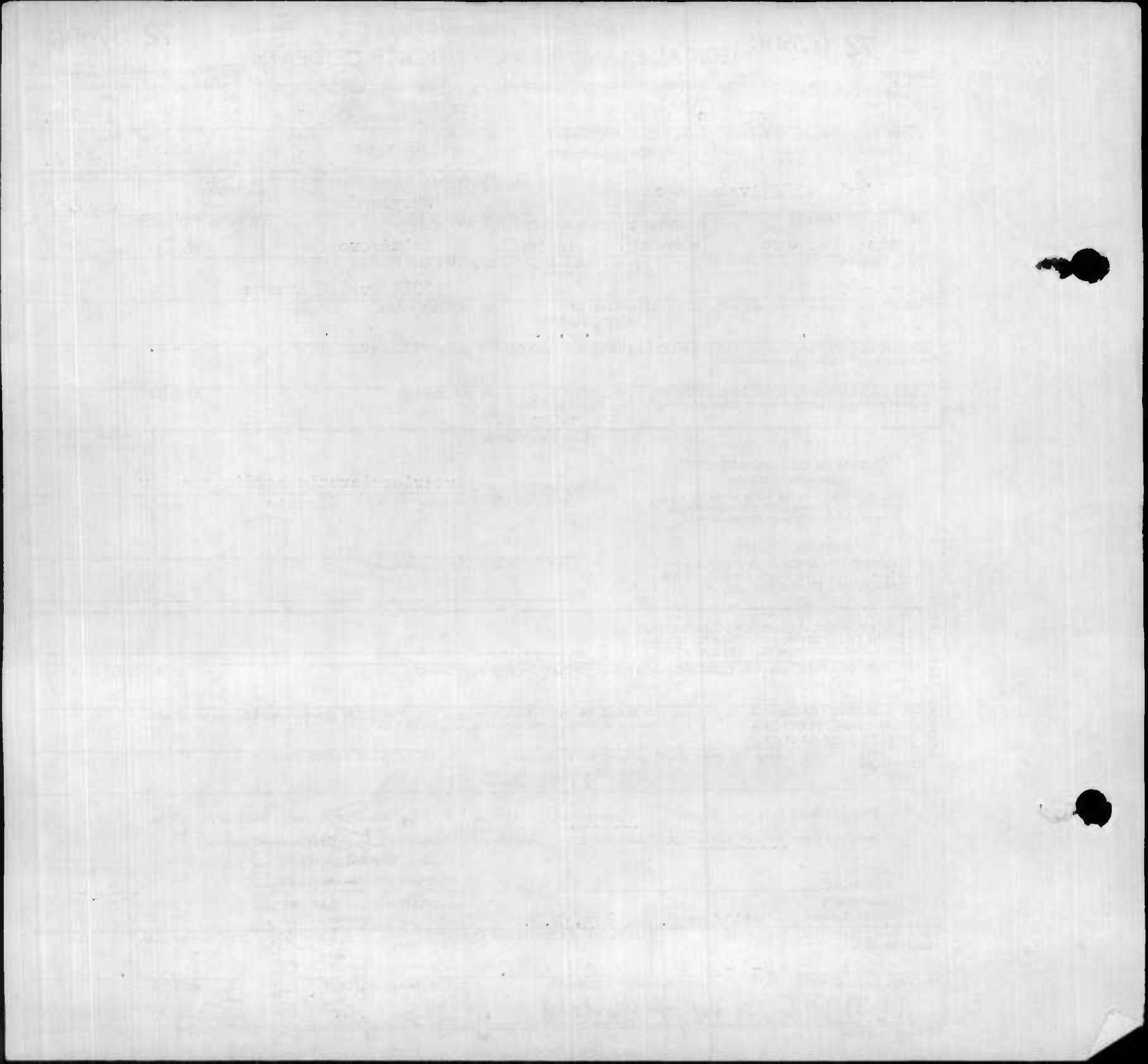
Sidney W. Boston

25C. FUNERAL DIRECTOR

Kelson F.H.

ADDRESS

1348 Calhoun Street



72 07207

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07207

BIRTH NO.

REG. NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Alonzo Alston | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 7 Day 27 Year 72 Hour 11:00 P.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5100 Queensbury Avenue | | 3. DATE PRONOUNCED DEAD Month 7 Day 27 Year 72 Hour 11:00 P.M. | |
| 6. SEX Male | | 7. RACE Negro | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 6-5-21 | | 10. AGE (In years lost birth day) 51 | |
| 11. BIRTHPLACE (State or foreign country) N.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Alston | | 14. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 2717 | |
| 15. MOTHER'S MAIDEN NAME Lilly | | 16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 17. SOCIAL SECURITY NO. 220013330 | | 18. INFORMANT Mary Lou Alston | |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes 8-4-44*1-5-46 | | 20. ADDRESS same | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Gunshot and (A) IMMEDIATE CAUSE Shotgun wound of head DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 8-1-72 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 5100 Queensbury Avenue | | 22D. TIME OF INJURY (Approx.) Month 7 Day 27 Year 72 Hour 11:00 P.M. | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? shot by unknown assailants | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE W P Mulloy M.D. EXAMINER'S NAME (Type) William P. Mulloy, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-28-72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-1-72 | |
| 24C. NAME OF CEMETERY or CREMATORY Balto. Nat'l. Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Lidney | |
| 25C. FUNERAL DIRECTOR V. Bailey | | ADDRESS Kelson F.H. 1348 Calhoun Street | |

10010 ST

10010 ST



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 72 07208 |
|---|------------------|---|---|--|
| BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>Lunn, Hattie V.</u> | | STATE OF MARYLAND-DEME 2. DATE AND HOUR OF DEATH <u>11:20 AM July 26 1972</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>U. of Md. Hospital</u> <u>38</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Carrollton Ave.</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>709 N. Carrollton Ave</u> | | |
| 5. SEX <u>F</u> | 6. RACE <u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>9/24/1900</u> | 9. AGE (In years last birthday) <u>71</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>North Carolina</u> |
| 13. FATHER'S NAME <u>Henry Bell</u> | | 14. MOTHER'S MAIDEN NAME <u>Rachel Bell</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>217-304283</u> | | 17. INFORMANT <u>Effor Jones</u> |
| 18. <u>4109 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardiogenic Shock</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | ADDRESS <u>2226 N. Fulton Ave.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr.</u> <u>3 1/2 days</u> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>CVA</u> | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7/16/72</u> 19 <u>72</u> to <u>7/26</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>7/26</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <u>not</u> view the body after death. | | | | |
| 23A. SIGNATURE <u>Carl A. Galloway, M.D.</u> | | | 23B. DATE SIGNED <u>7/26/72</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>CARL A. Galloway, M.D.</u> | | | 23D. ADDRESS <u>U. of Md. Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>7/31/72</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem. Balto. Md</u> |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 31 1972</u> | | |
| 25B. NAME OF REGISTRAR <u>Dr. [Signature]</u> | | 25C. FUNERAL DIRECTOR <u>Williams Funeral Home 319 N. Ashwood</u> | | |

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C-640

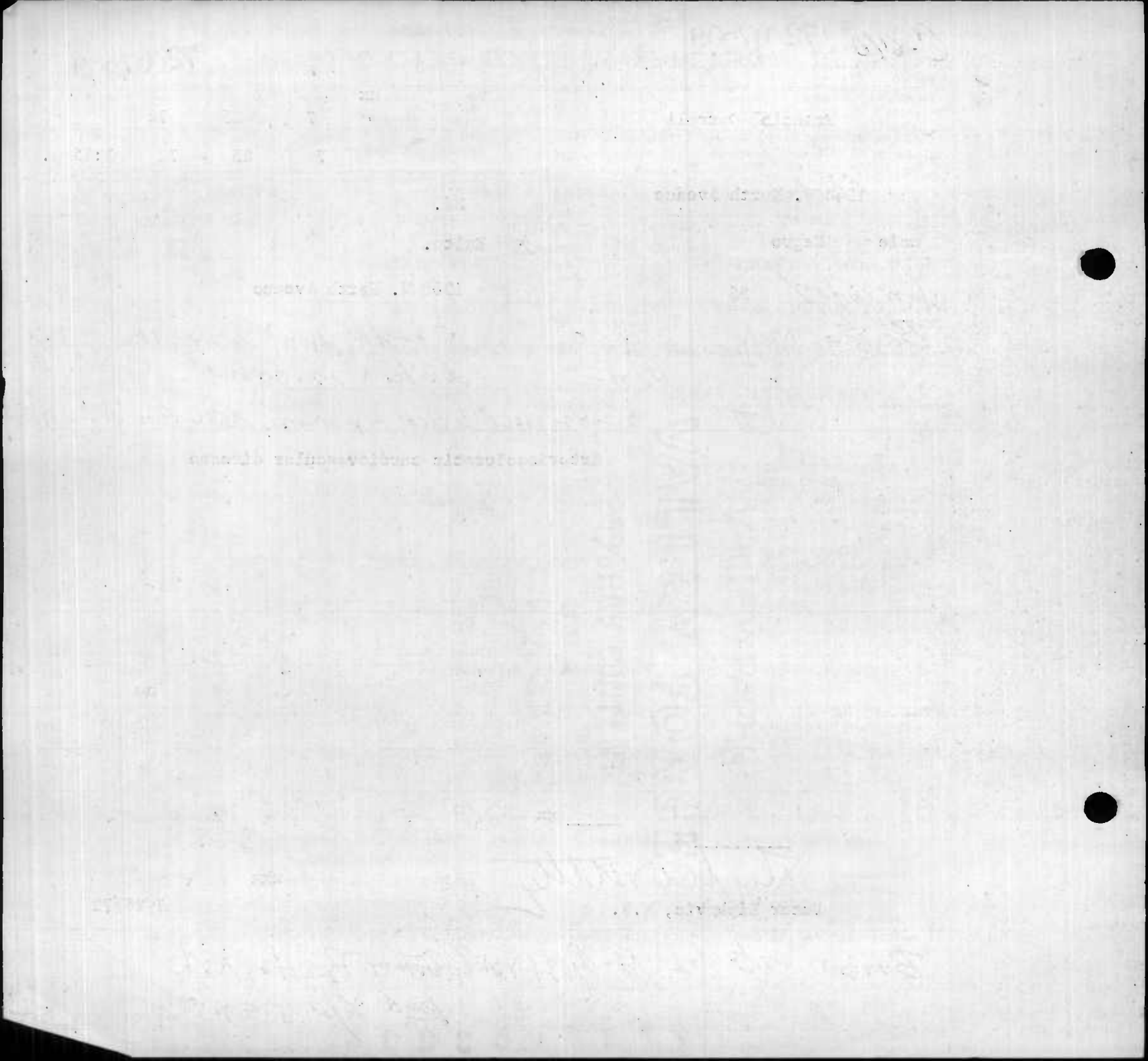
72 07209

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07209

BIRTH NO.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Francis Carroll | | | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 7 25 72 M. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital or institution, give street address or location) 1348 W. North Avenue | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 25 72 1:45 p.m. | | | |
| 6. SEX male | | | | 7. RACE Negro | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 9. DATE OF BIRTH Jan 16/12 | | | | 10. AGE (In years last birthday) 55 | | 11. BIRTHPLACE (State or foreign country) Balto, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME Frank W. Carroll | | | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 15. MOTHER'S MAIDEN NAME Lola Mason | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NA W H | | | | 17. SOCIAL SECURITY NO. 217-07-8284 | | 18. INFORMANT ADDRESS Clarice Hyman 3516 Forrest Park Ave | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 41241 | | | | 20. DATE OF OPERATION 7/31/72 | | | |
| 20A. DATE OF OPERATION 7/31/72 | | | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 21. AUTOPSY? (Yes or No) no | | | | 22. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 22F. HOW DID INJURY OCCUR? | | | | 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| 23. ACTUAL SIGNATURE Peter Lipkovic, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 7/31/72 | | | |
| 24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery Balto, Md. | | | | 24D. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | | | 25B. NAME OF REGISTRAR Adrian H. Heston | | | |
| 25C. FUNERAL DIRECTOR Wm S F/H. 31971 Schroeder | | | | 25D. ADDRESS | | | |



72 07210

STATE OF MARYLAND - DEPT.
BALTIMORE CITY HEALTH DEPARTMENT

72 07210

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)(LENPI LINDROOS)
LENPI LENDORSS2. DATE
OF
DEATHKnown ☒
Estimated ☐

Month

Day

Year

Hour

July 25, 1972

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF
HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

617 S. Newkirk Street

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

July 25, 1972

5:30 P.

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

2607

6. SEX

Female

7. RACE

White

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Dec. 18, 1904

10. AGE (in years
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

617 S. Newkirk Street

11. BIRTHPLACE (State or foreign country)

Monessen, Penna.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Victor Niemenen

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife-custodian

14B. KIND OF BUSINESS OR INDUSTRY

Retired

15. MOTHER'S MAIDEN NAME

Sophia Pielsila

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

none

18. INFORMANT

ADDRESS

Mr. Elis Leo Lindroos-617 S. Newkirk St

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Fatty metamorphosis of liver

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (if in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Marvin S. Platt, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 26, 1972

24A. BURIAL CREMATION,
REMOVAL (Specify)

Cremation

24B. DATE

7/28/72

24C. NAME of CEMETERY or CREMATORY

Greenmount Crematorium

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

Jul 31 1972

25B. NAME OF REGISTRAR

Sidney H. Hontela

25C. FUNERAL DIRECTOR

ADDRESS

H. Sander & Sons, Inc., Balto.

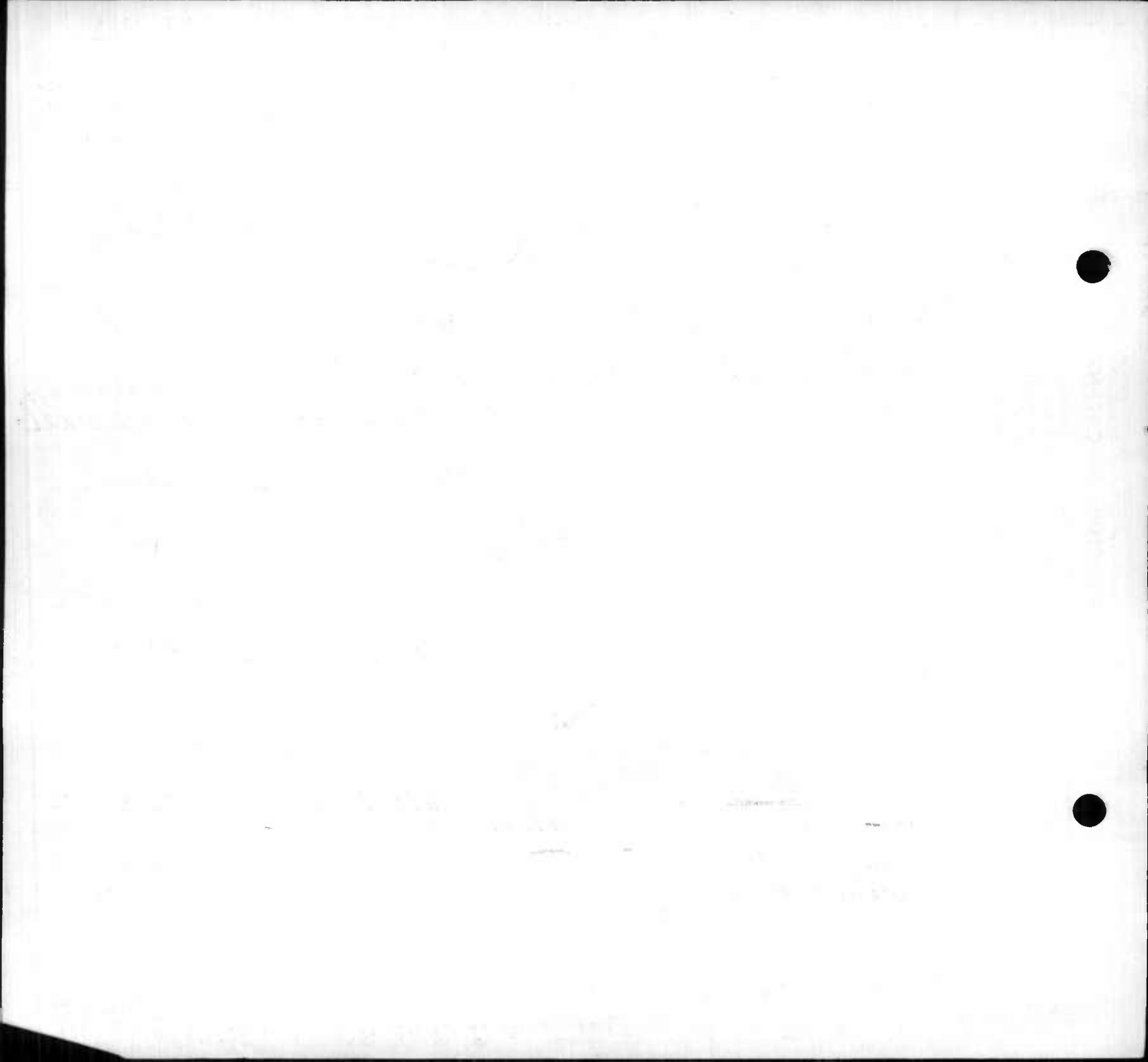
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X

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 72 07211 STATE OF MARYLAND-DEMH | |
|---|------------------|--|---|---|---|
| 1. NAME OF DECEASED (Type or Print) <u>Freida Limroth</u> | | 2. DATE AND HOUR OF DEATH <u>7/28/72</u> <u>12 30</u> A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 House in the Pines</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>909</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1341 East North Ave</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>SEPT 13, 1984</u> | 9. AGE (In years last birthday) <u>87</u> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PROPRIETOR</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PROPRIETOR</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u> | | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>WILLIAM F. LIMROTH</u> | | 14. MOTHER'S MAIDEN NAME <u>ANNA KNIPP</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>MRS. JANE C. SMITH</u> ADDRESS <u>2232 MONOCACY BALTO MD 21221</u> | | | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic Heart Disease</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> |
| | | | (B) <u>Coronary Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: | | <u>yes</u> |
| | | | (C) _____ | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Old Stroke in 1961; recent urinary tract infection</u> | | | | | |
| 19A. DATE OF OPERATION <u>7/28/72</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notifiy medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (she) attended the deceased from <u>4/26/1961</u> to <u>7/28/1972</u> that <u>she</u> last saw the deceased alive on <u>7/12/1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Albert B. Bradley</u> | | | | 23B. DATE SIGNED <u>7/28/72</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Henry Sender & Sons Inc</u> | | | | 23D. ADDRESS <u>BALTO MD</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u> | | 24B. DATE <u>7/29/72</u> | | 24C. NAME of CEMETERY or CREMATORY <u>WOODSON PARK CREMATORY</u> | |
| 24D. LOCATION <u>BALTO. MD</u> | | 24E. NAME of REGISTRAR <u>Henry Sender & Sons Inc</u> | | 24F. FUNERAL DIRECTOR <u>Henry Sender & Sons Inc</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 31 1972</u> | | 25B. NAME OF REGISTRAR <u>Henry Sender & Sons Inc</u> | | 25C. FUNERAL DIRECTOR <u>Henry Sender & Sons Inc</u> | |



X-520

72 07212

STATE OF MARYLAND-DEATH
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07212

REG. NO.

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) (LOUISE A. YOUNG) Louis A. Young | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 7 Day 26 Year 72 Hour M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 602 E. 27th Street | | 3. DATE PRONOUNCED DEAD Month 7 Day 26 Year 72 Hour 9:45 a.m. | |
| 6. SEX female | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH Dec. 24, 1892 | | 10. AGE (In years last birthday) 79 | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Manger | | 14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 904 | |
| 15. MOTHER'S MAIDEN NAME Sophie | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 17. SOCIAL SECURITY NO. 217-01-9679D | | 18. INFORMANT ADDRESS Herman Dorsch-1700 Meridene Dr. 12 | |
| 19. 412.4 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 7/28/72 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED no | |
| 21. AUTOPSY? (Yes or No) no | | 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 23. | |
| I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED 7/26/72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/28/72 | |
| 24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Sidney [Signature] | |
| 25C. FUNERAL DIRECTOR H. Sander & Sons, Inc., Balto., | | 25D. ADDRESS | |

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P-355

72 07213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 07213

STATE OF MARYLAND-DEMH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

James A. Pittman

2. DATE AND HOUR OF DEATH
July 29, 1972 4:50 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals
4940 Eastern Ave., Baltimore, Md. 21224

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY

Maryland Baltimore

C. CITY OR TOWN

ESSEX

D. INSIDE CITY LIMITS?

YES ☐ NO ☒

E. STREET AND NUMBER

1639 Dartford Road 21221

5. SEX

Male

6. RACE

Caucasian

7. MARRIED

☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

2/7/22

9. AGE (In years last birthday)

50

If Under 1 Yr. Months

If Under 24 Hrs. Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SELF EMPLOYED

10B. KIND OF BUSINESS OR INDUSTRY

TRUCKING

11. BIRTHPLACE (State or foreign country)

KENTUCKY

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

ARTHUR (Archie) PITTMAN

14. MOTHER'S MAIDEN NAME

Myrtle HATTER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

YES

WW II

16. SOCIAL SECURITY NO.

17. INFORMANT

Records: BCH-4940 Eastern Ave. 21224

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Heart Failure
tumor involvement of pericardium + myocardium

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 month

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/20 19 72 to 7/29 19 72 that (I) (we) last saw the deceased alive on 7/28 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Matthew N. Fine MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

7/29/72

23C. PHYSICIAN'S NAME (Type)

Matthew N. Fine

23D. ADDRESS

Baltimore City Hospitals
4940 Eastern Avenue, Baltimore, Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

8-1-72

24C. NAME OF CEMETERY or CREMATORY

POPLAR HILL CEMETERY LIBERTY

24D. LOCATION (City, town, or county) (State)

KENTUCKY

25A. DATE REC'D BY HEALTH DEPT.

JUL 31 1972

25B. NAME OF REGISTRAR

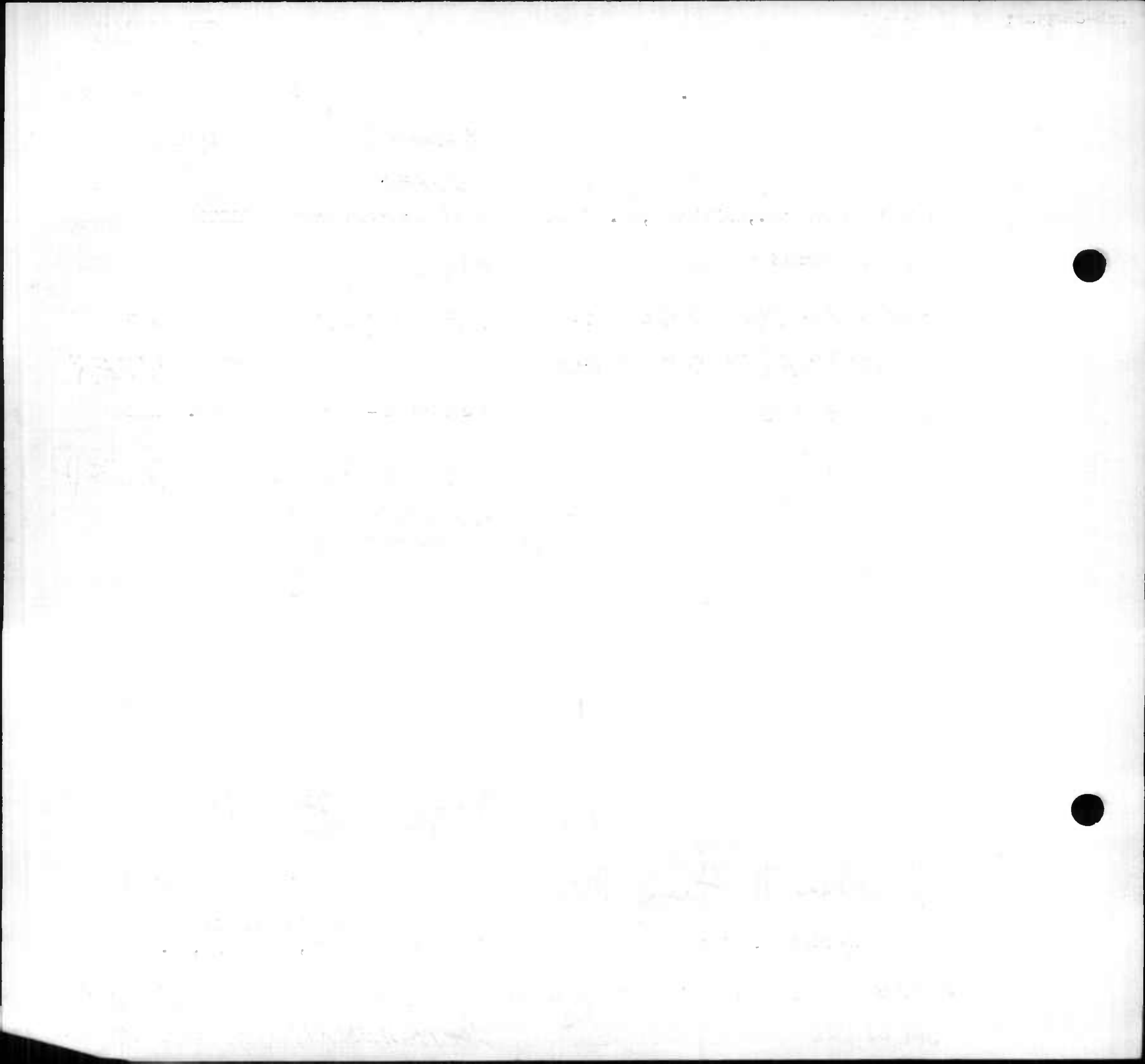
Didney W. Horton

25C. FUNERAL DIRECTOR

JOHN M. WEBERTSON INC. 4015 CHEST

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|---|--|
| C-600 72 07214 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 72 07214 STATE OF MARYLAND-DECEASED | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>Austin Carr</i> | | 2. DATE AND HOUR OF DEATH <i>7/25/72 3:35 P.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>HARFORD</i> | | 5. SEX <i>Male</i> 6. RACE <i>Negro</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>39</i> <i>Provident Hospital, Inc.</i> <i>2600 Liberty Height Ave.</i> <i>Baltimore, Md. 21215</i> | | C. CITY OR TOWN <i>Green Mountain Circle</i> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| E. STREET AND NUMBER <i>10850 Green Mountain Circle</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>8-16-80</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday) <i>91</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Virginia</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Rawleigh Carr</i> | |
| 14. MOTHER'S MAIDEN NAME <i>Martha Carr</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>231-52-8912</i> | |
| 17. INFORMANT <i>Alberta Mangana (DAUGHTER) SAME</i> | | 18. CAUSE OF DEATH <i>412.41</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Acute Myocardial Failure</i> <i>Chronic Atherosclerotic Cardiovascular Disease</i> <i>Chronic Brain Syndrome</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Indeterminate</i> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) <i>NO</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <i>4-6</i> 19 <i>72</i> to <i>7-25</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>7-25</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>G. F. Guacena Jr. M.D.</i> | | 23B. DATE SIGNED <i>7/25/72</i> | | 23C. PHYSICIAN'S NAME (Type) <i>GONZALO GUACENA, JR. M.D.</i> | |
| 23D. ADDRESS <i>Provident Hospital, Balto. Md.</i> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>7/29/72</i> | |
| 24C. NAME of CEMETERY or CREMATORY <i>Belleville Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>New Port News, Virginia</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>JUL 31 1972</i> | |
| 25B. NAME OF REGISTRAR <i>Dorothy Johnson</i> | | 25C. FUNERAL DIRECTOR <i>Mrs. Mary E. Law</i> | | ADDRESS <i>802 Madison Ave.</i> | |

4C. should be columbia, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| J-635 | | 72 07215 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07215 | |
|---|---------|--|--|---|--|--|-----------------------------|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | STATE OF MARYLAND-DHME | |
| | | Jordan, Essie Mae | | 7-26-72 7:19 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE & COUNTY | | | |
| Hospital University of Maryland | | | | MD. Wicomico 7200 | | | |
| | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | | | Salisbury | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER | | | |
| | | | | 505 Douglas Place | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| F | N | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 10-12-30 | | 41 | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | | | | | No C. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| S.T. Davis | | | | Mamie Scott | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | | | | | 1212 Morningstar Dr. ADDRESS | |
| | | | | | | Mrs. Mamie Scott Davis Wahalla, S. Carolina | |
| 18. 199.01 | | | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | Cardiac Failure | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | | | Septic Shock | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | Carcinomatosis | | | |
| (C) | | | | | | | |
| II | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 7-5-72 | | Carcinoma | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 1, 1972 to July 26, 1972 that (I) (we) lost saw the deceased alive on July 26, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| B. L. Hamilton M.D. | | | | 7-26-72 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | | | |
| B. L. HAMILTON | | M.D. Hospital University Maryland | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 7/31/72 | | Wildwood Memorial Park | | Seneca, South Carolina | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JUL 31 1972 | | S. J. Hamilton | | Mrs. Mary E. Law | | 802 Madison Ave. | |

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10-12-30
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N.C.
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10-12-30

1

72 07216 STATE OF MARYLAND-DEMH
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

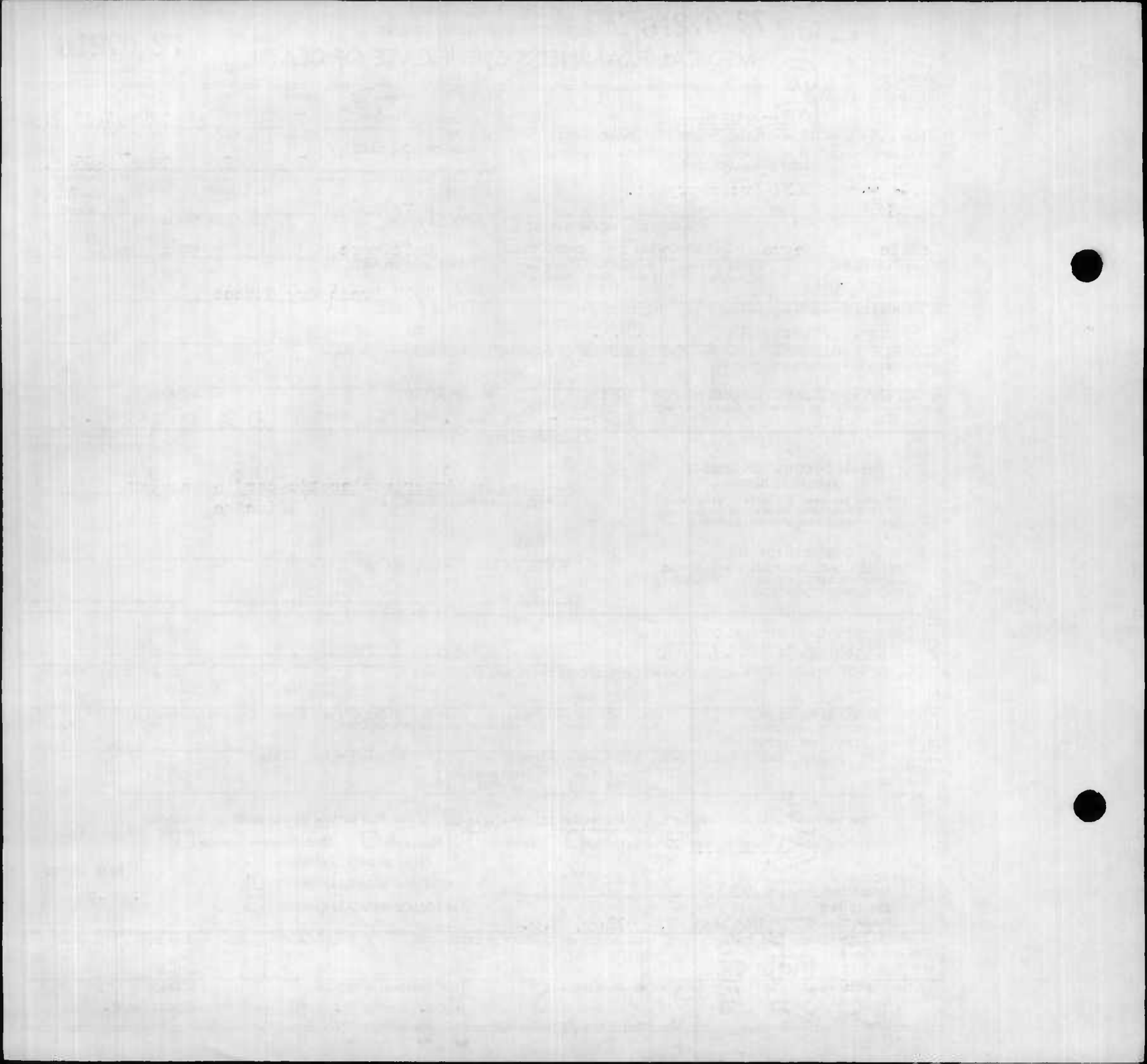
72 07216

REG. NO.

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Mary Wilson | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 7 27 72 4:55 P. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2832 Pressbury St. | | 3. DATE PRONOUNCED DEAD Month Day Year 7 27 72 4:55 P. M. | |
| 6. SEX Female | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 6/18/1974 | | 10. AGE (In years lost birthday) 98 | |
| 11. BIRTHPLACE (State or foreign country) Norfolk, Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 17. SOCIAL SECURITY NO. 226-70-2219 | |
| 18. INFORMANT Mrs. Millie BERGANS | | ADDRESS 2832 Presbury St. | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE W P Mulloy M.D. EXAMINER'S NAME (Type) William P. Mulloy, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/1/72 | |
| 24C. NAME OF CEMETERY or CREMATORY Calvary Cemetery | | 24D. LOCATION (City, town, or county) (State) Norfolk, Virginia | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Sidney H. Horton | |
| 25C. FUNERAL DIRECTOR Mrs. Mary E. Law | | ADDRESS 802 Madison Ave. | |

4720003213



72 07217

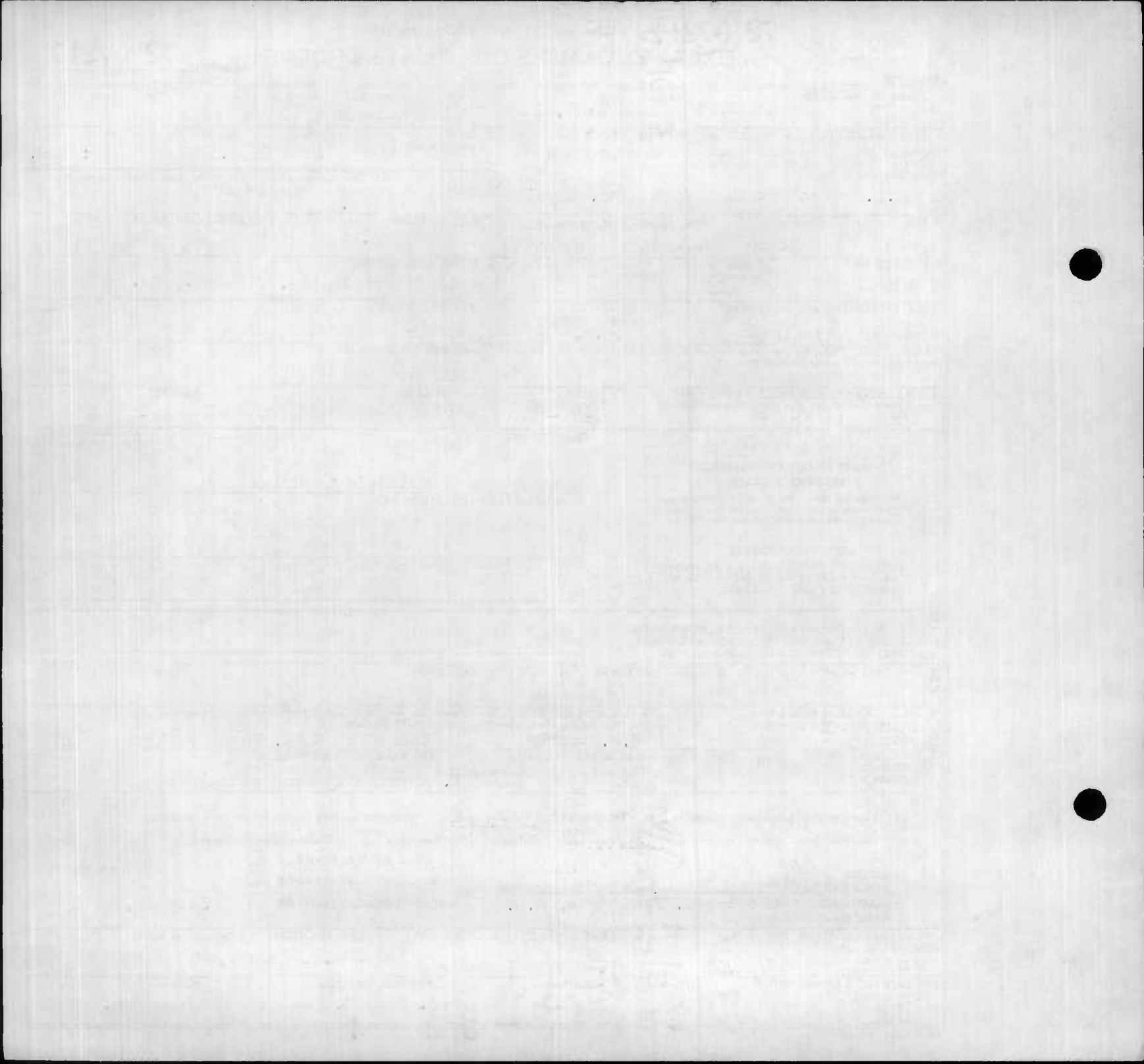
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07217

BIRTH NO.

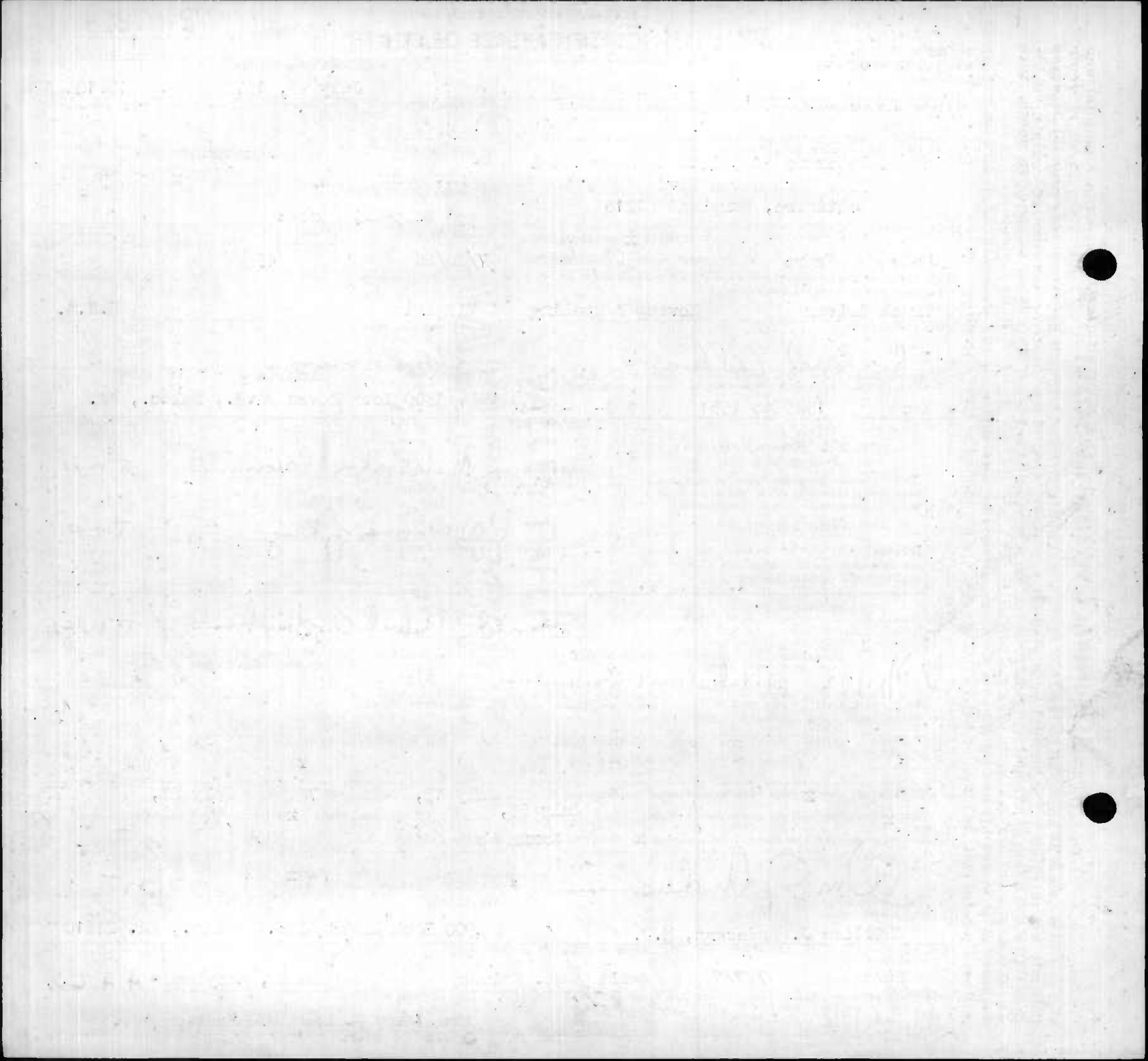
| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) ARTHUR FLETCHER TATE, III | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) R.R. tunnel at Cathedral & Mt. Royal | | 3. DATE PRONOUNCED DEAD Month Day Year Hour June 29, 1972 11:50 P.M. | |
| 6. SEX Male | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 3/5/47 | | 10. AGE (In years lost birthday) 25 | |
| 11. BIRTHPLACE (State or foreign country) Richmond, Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes Viet Nam | | 17. SOCIAL SECURITY NO. 223-70-4535 | |
| 18. INFORMANT Charles Tate | | ADDRESS 3414 Dolefield Ave. | |
| 19. CAUSE OF DEATH 5-8051.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Multiple injuries DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) R.R. tracks | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Cathedral & Mt. Royal railroad tracks | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) ? ? ? ? | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Apparently accidentally run over by train | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 26, 1972 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/28/72 | |
| 24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery | | 24D. LOCATION (City, town, or county) (State) A.A. County, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Sidney B. Whitson | |
| 25C. FUNERAL DIRECTOR Mrs. Mary E. Law | | ADDRESS 802 Madison Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

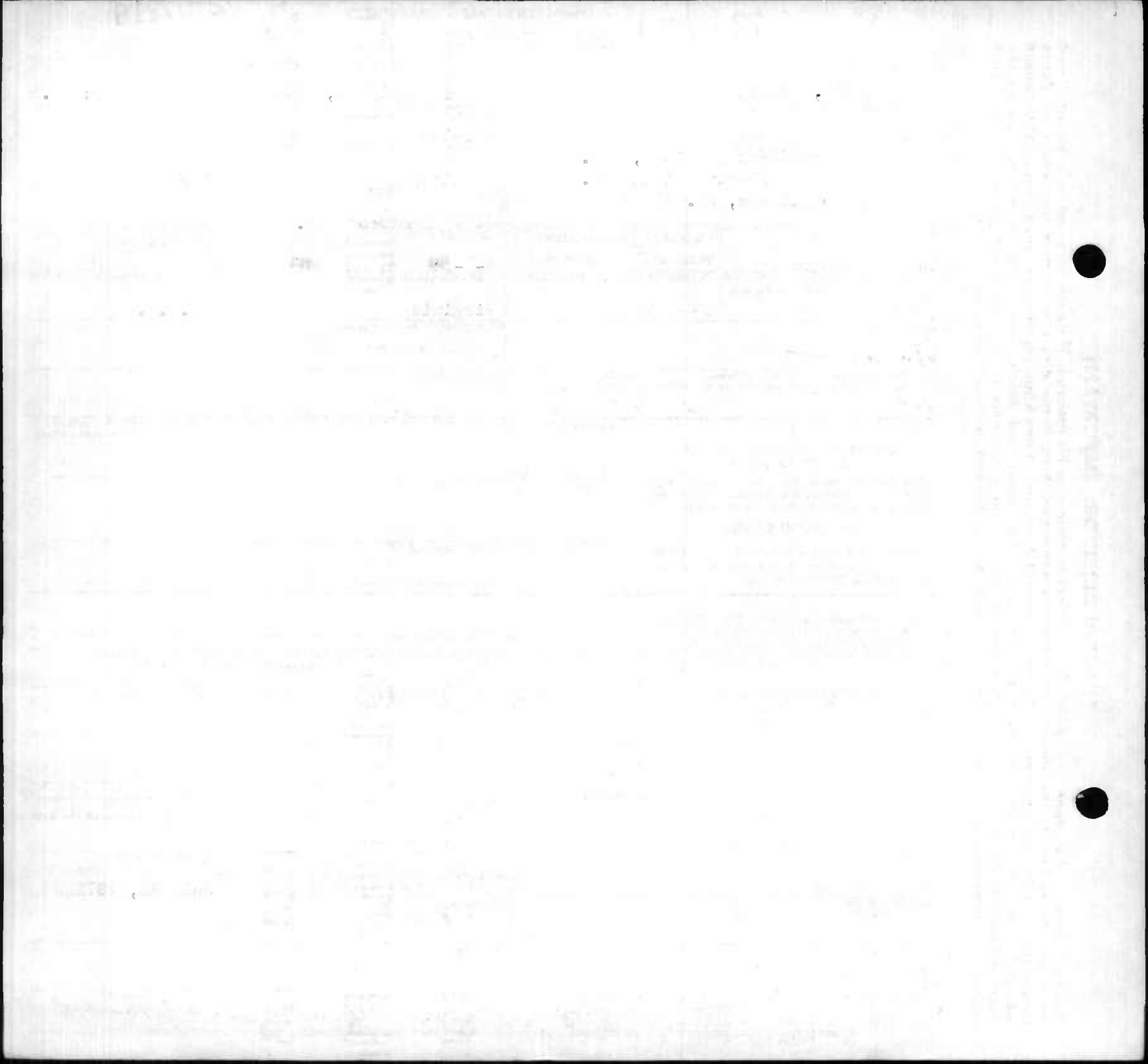
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07218 | | REG. NO. 72 07218 | |
|--|-------------------------|---|------------------------------------|---|------------------------------------|---|--|
| BIRTH NO. 72 07218 | | | | CERTIFICATE OF DEATH | | | |
| STATE OF MARYLAND-DHMH | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>ALLEN, Walter Elles</u> | | | | 2. DATE AND HOUR OF DEATH <u>July 23, 1972</u> <u>12:10 A.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Veterans Administration Hospital</u> <u>3900 Loch Raven Blvd</u> <u>Baltimore, Maryland 21218</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1702</u> | | | |
| | | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER <u>520 Dolphin, Street</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/28/26</u> | 9. AGE (In years last birthday) <u>45</u> | If Under 1 Yr. Months: Days: _____ | If Under 24 Hrs. Hours: Min. _____ | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Moving & hauling</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Richard Allen</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <u>1945 to 1951</u> | | 16. SOCIAL SECURITY NO. <u>229-22-08-48</u> | | 17. INFORMANT <u>Records</u> ADDRESS <u>VAH, 3900 Loch Raven Blvd., Balto., Md.</u> | | | |
| 18. <u>162.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Small Bowel Obstruction</u> | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Metastatic Carcinoma</u> (B) <u>Carcinoma of lung</u> (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Two</u> <u>Two</u> <u>it wks</u> | |
| 19A. DATE OF OPERATION <u>7/19/72</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Intestinal Obstruction</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (H) (this hospital) attended the deceased from <u>July 13, 1972</u> to <u>July 23, 1972</u> , that (H) (we) last saw the deceased alive on <u>July 23, 1972</u> and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>William J. Anderson</u> DEGREE _____ | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>7/25</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>William J. Anderson, M.D.</u> DEGREE _____ | | | | 23D. ADDRESS <u>3900 Loch Raven Blvd., Balto., Md. 21218</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>7/27/72</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>XXXX Mt. Calvary</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland - A.A. Co.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 31 1972</u> | | 25B. NAME OF REGISTRAR <u>Sidney H. ...</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Mrs. Mary E. Law 802 Madison Ave.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|-----------------------------------|---|---|
| E-400 | | 72 07219 | | 72 07219 | |
| BIRTH NO. | | | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) Ewell, Edward | | | | 2. DATE AND HOUR OF DEATH July 26, 1972 3:50a.m. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital, Inc. 2600 Liberty Height Ave. Baltimore, Md. 21215 | | | | A. STATE Maryland B. COUNTY 1603 | |
| C. CITY OR TOWN Baltimore | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER 1619 Edmondson Ave. | | | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-1-89 | 9. AGE (in years last birthday) 83 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor | | 10B. KIND OF BUSINESS OR INDUSTRY R. R. | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME Y. K. K. | | | | 14. MOTHER'S MAIDEN NAME W. K. K. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. A547634 | | 17. INFORMANT Fannie Wilson (DAUGHTER) SAME AS ABOVE | |
| 18. CAUSE OF DEATH 4/0/9 I | | | | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Severe Coronary insufficiency. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| | | | | (C) Severe dehydration. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 7/26/72 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/24 19 72 to 7/26 19 72 that (I) (we) lost saw the deceased alive on 7/26 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE H. Bengzon, M.D. | | | | 23B. DATE SIGNED July 26, 1972 | |
| 23C. PHYSICIAN'S NAME (Type) H. BENGZON, M.D. | | | | 23D. ADDRESS PROVIDENT HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/29/72 | | 24C. NAME OF CEMETERY OR CREMATORY St. Bernard | |
| 24D. LOCATION (City, town, or county) (State) BALTO MD | | | | | |
| 25A. DATED BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Alvin J. Johnson | | 25C. FUNERAL DIRECTOR Alvin J. Johnson | |
| 25D. ADDRESS 6380 Gibson St | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| J-525 | | 72 07220 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07220 | |
|--|--|--|--|---|--|--|--|
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| Johnson, Mary E. | | | | 7/29/72 E 1 45 P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | | | |
| 33 JOHNS HOPKINS HOSPITAL BALTIMORE, MARYLAND 21205 | | | | MARYLAND 1703 | | | |
| C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | | E. STREET AND NUMBER | | F. INSIDE CITY LIMITS? | |
| BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 851 GEORGE ST. APT 11 A | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| FEMALE | | WHITE | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 10/18/18 | |
| 9. AGE (In years last birthday) | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 53 | | LAUNDRY | | GASTONIA N.C. | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| ROBERT STEVENSON | | | | BESSIE POTLOW | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| NO | | | | Robert S. Stevenson 202 N. MURRAY ST. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 6/6/01 - 099.1 | | | | 24 hours | | | |
| ANTECEDENT CAUSES | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | Renal failure acute hyperkalemia | | | |
| II | | | | (B) massive infection | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | uncertain | | | |
| lymphogranuloma venereum | | | | 25 years | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 7/26/72 | | massive pelvic infection | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| NO | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/14/72 19 to 7/29 19 72 | | | | | | | |
| that (I) (we) last saw the deceased alive on 7/29 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Lonny G. Garth Close MD | | | | 7/29/72 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| LONNY G. GARTH CLOSE M.D. | | | | Johns Hopkins Hosp. Balt., Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 8/3/72 | | Mt. Calvary | | Baltimore MD | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JUL 31 1972 | | Dorothy Whitton | | Dorothy Whitton | | 638 N. 1st St | |

100-100000

100-100000

100-100000

72 07221

STATE OF MARYLAND-DEMD
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07221

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Etta Vaughn (Vaughan) | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 7 25 72 M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2206 McCulloh St. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 25 72 2:50 p. M. | |
| 6. SEX female | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 8/20/00 | | 10. AGE (In years last birthday) 65 71 | |
| 11. BIRTHPLACE (State or foreign country) Prince George's Co. Md. | | 12. CITIZEN OF USA | |
| 13. FATHER'S NAME ROBERT RACEIGH | | 14. MOTHER'S MAIDEN NAME KATIE | |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 16. KIND OF BUSINESS OR INDUSTRY At Home | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) W | | 18. SOCIAL SECURITY NO. | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 20A. DATE OF OPERATION 7/25/72 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) no | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Peter Lipkovic, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 7/26/72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | |
| 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Adrienne Whitton | |
| 25C. FUNERAL DIRECTOR Blond F/H. Porosburg Co | | ADDRESS | |

100-100000-100

100-100000-100

100-100000-100

100-100000-100

100-100000-100

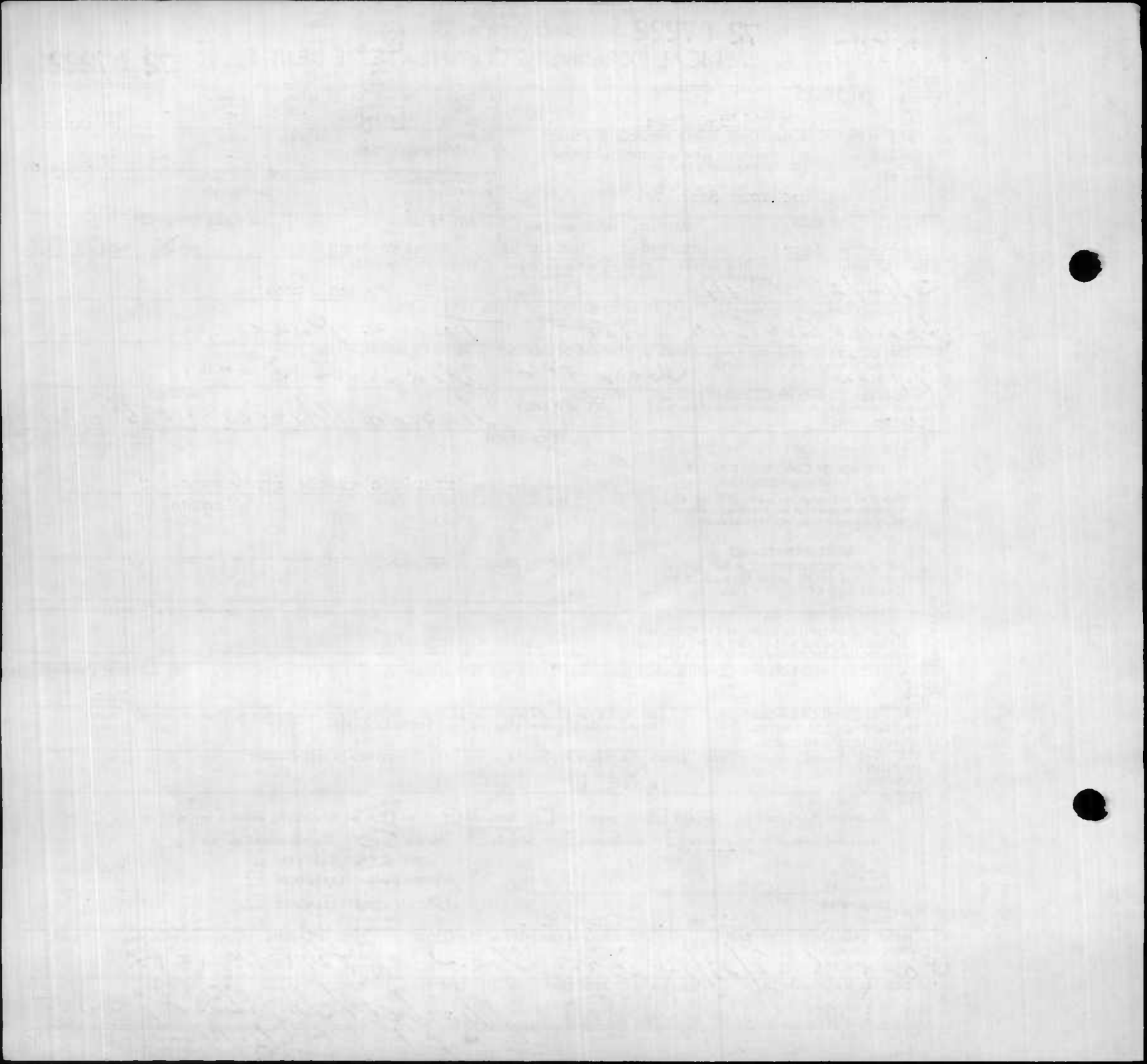
J-520

STATE OF MARYLAND-DMH
BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07222

BIRTH NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Mildred Jones | | | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 7 27 72 10:15 P.M. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 27 72 10:15 P.M. | | | |
| 6. SEX Female | | | | 7. RACE Negro | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH 3/12/28 | | | | 10. AGE (In years last birthday) 44 | | 11. BIRTHPLACE (State or foreign country) Prince George's Co. Md. | |
| 12. CITIZEN OF USA | | | | 13. FATHER'S NAME THOMAS PARKER | | | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse | | | | 15. MOTHER'S MAIDEN NAME VIRGINIA FURNS | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT Virginia Blizman | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | 20. IMMEDIATE CAUSE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic cardiovascular disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | | |
| 20A. DATE OF OPERATION | | | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | | 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE W P Mulloy M.D. EXAMINER'S NAME (Type) William P. Mulloy, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE 7/21/72 | | | |
| 24C. NAME OF CEMETERY or CREMATORY East View | | | | 24D. LOCATION (City, town, or county) (State) Petersburg VA | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | | | 25B. NAME OF REGISTRAR Sidney Johnson | | | |
| 25C. FUNERAL DIRECTOR Marshall R. Rapp | | | | 25D. ADDRESS 1000 Bladell St. N. Petersburg VA | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07223 | |
|--|--|--|--|---|--|
| BIRTH NO. W-300 | | | | 72 07223 | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | |
| JAMES FRANK WHITE | | | | July 31, 1972 2:45 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | |
| US Public Health Service Hospital 3100 Wyman Parkway | | | | Md. 1513 | |
| 5. SEX M 6. RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH 10/27/10 9. AGE (In years last birthday) 61 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian | | | | 11. BIRTHPLACE (State or foreign country) NC | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Alfred White | | | | 14. MOTHER'S MAIDEN NAME Charlotte Alexander | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USA 1941-1945 | | | | 16. SOCIAL SECURITY NO. 213 -07-6764 | |
| 17. INFORMANT | | | | ADDRESS | |
| Records- US PHS Hospital, Balto, Md. | | | | | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | Days | |
| (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II Left neck mass | | | | Weeks | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I)/(this hospital) attended the deceased from July 6 19 72 to July 31 19 72, that (I)/(we) last saw the deceased alive on July 31 19 72 and that in (my)/(our) opinion death occurred on the date and hour and from the causes stated above, (I)/(We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Vija L. Bauer, M.D. | | | | 7/31/72 | |
| 23C. PHYSICIAN'S NAME (Type) Vija L. Bauer, Sr. Surgeon (R) | | | | 23D. ADDRESS | |
| | | | | US PHS Hospital, Balto, Md. 21211 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 8/1/72 | | Mt Calvary | |
| 24D. LOCATION (City, town, or county) | | 24E. NAME OF REGISTRAR | | 24F. FUNERAL DIRECTOR | |
| Clen Burnio MD | | Indy... | | M... | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| | | | | | |

July 2, 1945

Dear Mr. [illegible]

I am very sorry to hear

that you are

ill

and hope you are

getting better

very soon

Yours truly,

[Signature]

Very truly yours,

cc

cc

cc

cc

[Signature]

(2) [illegible]

cc [illegible]

S-530

72 07224

STATE OF MARYLAND-DEPT
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07224

REG. NO.

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Roma Romy Smith | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 7 24 72 | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2100 Mt. Royal Terr. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 24 72 5:05 p. | |
| 6. SEX male | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH JAN 1-1911 | | 10. AGE (In years last birthday) 61 | |
| 11. BIRTHPLACE (State or foreign country) LANCASTER, PA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME ANDREW SMITH | | 14. MOTHER'S MAIDEN NAME VIRGINIA THOMAS | |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | 16. KIND OF BUSINESS OR INDUSTRY | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 18. SOCIAL SECURITY NO. | |
| 19. CAUSE OF DEATH E9661X | | 20. ADDRESS 221 N Fremont Ave | |

| | | | |
|--|--|--|--|
| 19. CAUSE OF DEATH E9661X | | 20. ADDRESS 221 N Fremont Ave | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |

| | | | | | |
|---|--|--|--|---|--|
| 20A. DATE OF OPERATION 7/25/72 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2100 Mt. Royal Terr. | |
| 22D. TIME OF INJURY (APPROX.) Month Day Year Hour 7 24 72 unk | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Subject stabbed by unknown assailant. | |

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|---|--|--|--|-------------------------------|--|
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 7/25/72 | |
| ACTUAL SIGNATURE Peter Lipkovic, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/25/72 | | 24C. NAME OF CEMETERY or CREMATORY Wt. Auburn | | 24D. LOCATION (City, town, or county) (State) Baltimore MD | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | | 25B. NAME OF REGISTRAR Arden Whorton | | 25C. FUNERAL DIRECTOR Marshall & Sons | | ADDRESS 635 N 39 | |

3-22-55

Dear Mr. [illegible]
[illegible]
[illegible]
[illegible]

Very truly yours,
[illegible]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Edward Bell | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 7 25 72 | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2406 Annor Ct. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 25 72 10:50 a. | |
| 6. SEX male | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2543 | |
| 9. DATE OF BIRTH 1-8-27 | | 10. AGE (In years lost birthday) 45 | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 15. MOTHER'S MAIDEN NAME Edna Williams | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT ADDRESS Regina Williams 2548 Boyd Street | |
| 19. 4124 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Cirrhosis of liver | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | 22. DATE OF OPERATION | |
| 23. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 24. AUTOPSY? (Yes or No) NO | |
| 25. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 27. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 28. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | |
| 29. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 30. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED 7/26/72 | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | |
| 24B. DATE 7-29-72 | | 24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Anne Arundel Cty., Md. | | 25A. DATE REC'D BY HEALTH DEPT. JUL 31 1972 | |
| 25B. NAME OF REGISTRAR Sidney Johnson | | 25C. FUNERAL DIRECTOR ADDRESS Wm C March 928 E North A | |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|----------------------|---|---|--|--|---|--|--|--|
| N-630 | | 72 07226 | | BALTIMORE CITY HEALTH DEPARTMENT | | X | | REG. NO. 72 07226 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | | | STATE OF MARYLAND-DHMH | | | |
| 1. NAME OF DECEASED (Type or Print) NORTH, MATILDA AGNES | | | | 2. DATE AND HOUR OF DEATH JULY 30, 1972 4:50 P. M. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED OEO | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL WILKENS & CATON AVENUES BALTIMORE, MARYLAND 21229 | | | | MARYLAND | | BALTIMORE | | 21227 | |
| | | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| | | | | E. STREET AND NUMBER 3300 HOLLINS FERRY RD. 5300 | | | | | |
| 5. SEX FEMALE | 6. RACE CAUCASIAN | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12 13 98 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. Months: Days: | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | 13. FATHER'S NAME ERNEST KROUSE | | | 14. MOTHER'S MAIDEN NAME JULIA | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 215 031868 | | | 17. INFORMANT BALTIMORE, MD. 21229 ADDRESS ST AGNES RECORDS-CATON & WILKENS AVE. | | | |
| 18. 593.2.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiogenic shock</i> (B) <i>Arteriosclerotic Cardiovascular disease</i> (C) <i>Renal failure</i> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (X) (this hospital) attended the deceased from JULY 24, 19 72 to JULY 30, 19 72, that (X) (we) last saw the deceased alive on JULY 30, 19 72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>E. Henzan M.D.</i> | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 7/30/72 | |
| 23C. PHYSICIAN'S NAME (Type) EITATSU HENZAN, M.D. | | | | | | 23D. ADDRESS BALTIMORE, MARYLAND 21229 ST AGNES HOSPITAL-WILKENS & CATON AVES. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 8/3/72 | | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | | 25B. NAME OF REGISTRAR <i>Sidney W. Witzke</i> | | | 25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue | | ADDRESS 21228 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|--|--|--|---|--|
| E-420 72 07227 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07227 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | STATE OF MARYLAND-DHMH | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| ELLIS, EDWARD EDGAR | | JULY 29 1972 | | 5:00 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | | | |
| ST. AGNES HOSPITAL WILKENS & CATON AVENUES BALTIMORE, MARYLAND 21229 | | MD. BALTIMORE COUNTY | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| MALE | | CAUCASIAN | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| POLICEMAN | | CITY POLICE DEPT. | | WASHINGTON, D. C. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Emil | | | | UNITED STATES | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| YES WORLD WAR I | | 220 30 0514A | | ST. AGNES HOSPITAL RECORDS | |
| 18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | Cardiogenic shock | | 4 hs | |
| ANTECEDENT CAUSES | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | 12 hs | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | Acute interseptal MI | | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | ASCVD | | | |
| | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that X (this hospital) attended the deceased from JULY 29 1972 to JULY 29 1972, that X (we) last saw the deceased alive on JULY 29 1972 and that in my XXX (our) opinion death occurred on the date and hour and from the causes stated above. X (We) (did) XXXX view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| JOSE APTER, M.D. | | | | JULY 29 1972 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| JOSE APTER, M.D. | | | | ST. AGNES HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 8/2/72 | | Lorraine Park Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| AUG 1 1972 | | Sidney H. Heston | | Witzke, 1630 Edmondson Avenue 28228 | |

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125-1-105

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07228

BIRTH NO.

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) DONALD BEAMER | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 604 N. East Ave. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 30 1972 3:45p M. | |
| 6. SEX male | | 7. RACE white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 11/5/43 | | 10. AGE (In years last birthday) 28 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Unknown | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 15. MOTHER'S MAIDEN NAME Unknown | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 17. SOCIAL SECURITY NO. 212-42-0615 | | 18. INFORMANT ADDRESS Doris Beamer, 604 N. East Ave. 21205 | |
| 19. 304.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | CAUSE OF DEATH Intravenous narcotism (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 23. | |
| I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Marvin S. Platt, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-31-72 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/3/72 | |
| 24C. NAME OF CEMETERY or CREMATORY Moreland | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | 25B. NAME OF REGISTRAR Audrey Johnson | |
| 25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue | | ADDRESS | |

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07229

BIRTH NO.

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) LEO MC GEE | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2909 Ellicott Dr. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour M. 7 29 1972 10:15 | |
| 6. SEX male | | 7. RACE white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 7/24/03 | | 10. AGE (In years lost birthday) 69 | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME McGee | | 14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1607 | |
| 15. MOTHER'S MAIDEN NAME Josie | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 17. SOCIAL SECURITY NO. 212-10-9842 | | 18. INFORMANT Charles Trommer | |
| 19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20. DATE OF OPERATION 0 | | 21. AUTOPSY? (Yes or No) no | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE R. Fisher EXAMINER'S NAME (Type) Russell S. Fisher, M.D. | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-30-72 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/2/72 | |
| 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | 25B. NAME OF REGISTRAR Aidy Whiston | |
| 25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue | | ADDRESS 21228 | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

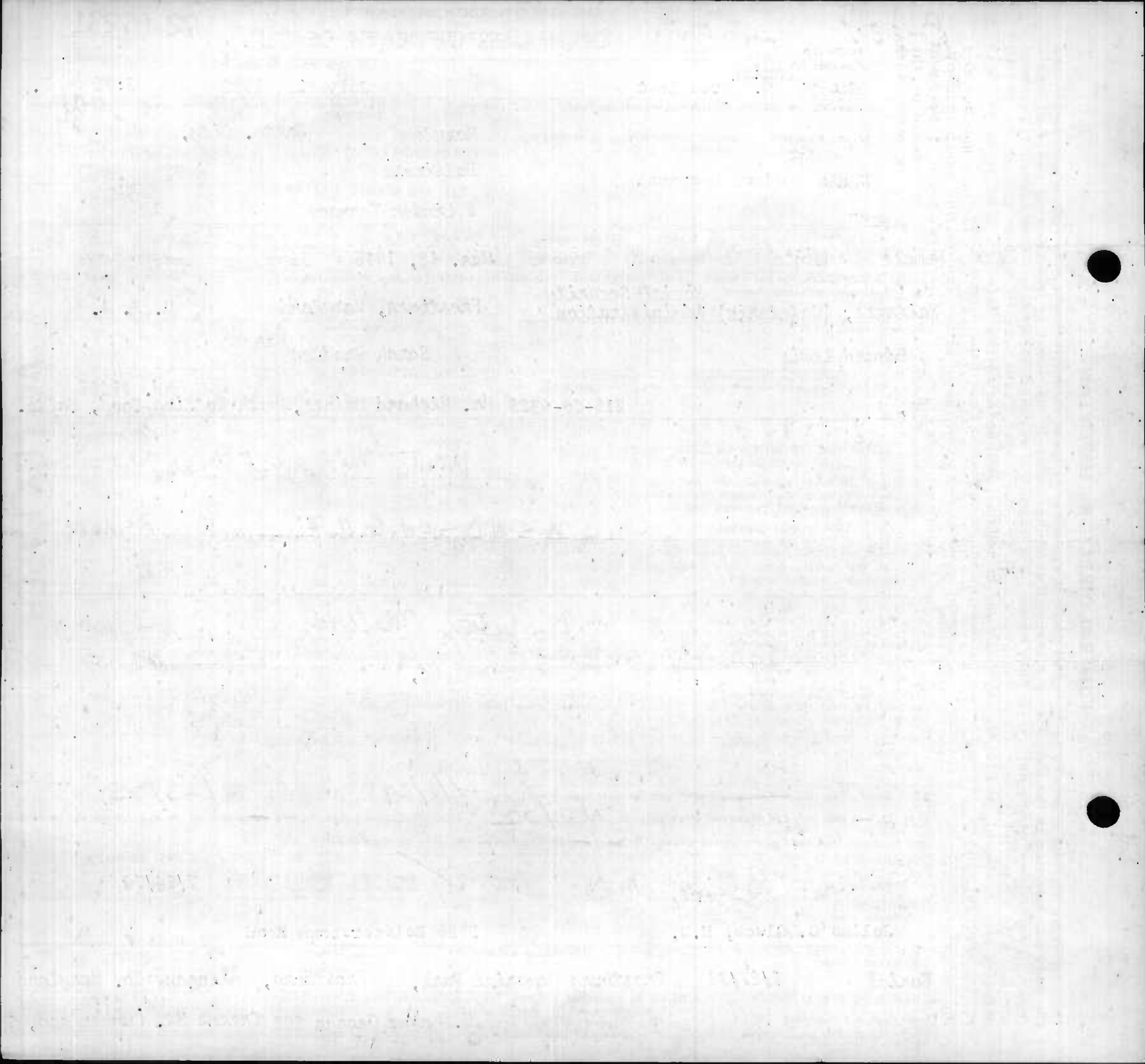
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07230 | | STATE OF MARYLAND - DIME | |
|--|--|---|--|---|--|---|--|
| BIRTH NO. 72 07230 | | | | 72 07230 | | 72 07230 | |
| 1. NAME OF DECEASED (Type or Print) Robert Ernest Cape | | | | 2. DATE AND HOUR OF DEATH July 24, 1972 5:20 A M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 10-5-72 3100 Wyman Parkway | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE NJ B. COUNTY V27 | | | |
| 5. SEX M | | | | 6. RACE Caucasian | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 10/27/26 | | | | 9. AGE (In years last birthday) 45 | | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 11. BIRTHPLACE (State or foreign country) NJ | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Ernest Cape | | | | 14. MOTHER'S MAIDEN NAME Anne Megaro | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USN 1944-1946 | | | | 16. SOCIAL SECURITY NO. 103-22-2520 | | 17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md. | |
| 18. 206.0 I Social Security No. 153-22-2520 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) SEPSIS & hemorrhage ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Thrombocytopenia Acute monocytic leukemia | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Weeks Months | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Apr. 26 19 72 to July 24 19 72, that (I) (we) last saw the deceased alive on July 24 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Arthur B. Abt, M.D. | | | | 23B. DATE SIGNED 7/24/72 | | 23C. PHYSICIAN'S NAME (Type) Arthur B. Abt, Surgeon | |
| 23D. ADDRESS US PHS Hospital, Balto, Md. | | | | 23E. FUNERAL DIRECTOR Robert A. Pumphrey, F.H.P., Bethesda, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | | 24B. DATE 7-26-72 | | 24C. NAME OF CEMETERY or CREMATORY Manteo, North Carolina | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | 25B. NAME OF REGISTRAR Sidney J. Boston | | 25C. FUNERAL DIRECTOR Robert A. Pumphrey, F.H.P., Bethesda, Md. | | 25D. ADDRESS | |

10-5-1972 - Affidavit of Wife, Eleanor Cape, 17 Delbarton Drive, Madison, New Jersey-07940
and Social Security Card for Robert E. Cape. HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | REG. NO. 72 07231 | |
|---|--|---|--|---|--|--|--|
| <div style="display: flex; justify-content: space-between;"> B-634 72 07231 </div> | | | | <div style="display: flex; justify-content: space-between;"> STATE OF MARYLAND-DHMH 72 07231 </div> | | | |
| 1. NAME OF DECEASED (Type or Print) Louise Gladys Breedlove | | | | 2. DATE AND HOUR OF DEATH July 23, 1972 3:00 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="display: flex; align-items: center;"> XXXX Sinai Hospital </div> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balto. City, 5300 | | | |
| 5. SEX Female 6. RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH Mar. 12, 1916 9. AGE (In years last birthday) 56 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress, (Cafeteria) 11. BIRTHPLACE (State or foreign country) Frostburg, Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Edward Lewis | | | | 14. MOTHER'S MAIDEN NAME Sarah Bradley | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No, | | | | 16. SOCIAL SECURITY NO. 215-20-6323 | | 17. INFORMANT Mr. Richard Haines ADDRESS Md. 21228 South Rolling Road, Balto. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <div style="font-size: 1.5em; margin-top: 10px;">410.9 142.50.9</div> | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate Death | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="text-align: center; font-weight: bold; margin-top: 20px;">II</div> | | | | (B) A.S.H.D - CH. G. H. 7. DUE TO, OR AS A CONSEQUENCE OF: (C) Diabetes Mellitus | | 3 years | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | 2 years | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No, | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/1/69 19 to 7/23/72 19 , that (I) (we) last saw the deceased alive on 7/8/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Julius C. Gluck, M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 7/24/72 | |
| 23C. PHYSICIAN'S NAME (Type) Julius C. Gluck, M.D. | | | | 23D. ADDRESS 5356 Reisterstown Road | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/27/72 | | 24C. NAME OF CEMETERY or CREMATORY Frostburg Memorial Park, | | 24D. LOCATION (City, town, or county) (State) Frostburg, Allegany Co. Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | 25B. NAME OF REGISTRAR H. Wayne George | | 25C. FUNERAL DIRECTOR 202 Greene St. Cumberland, | | ADDRESS Md. 21502 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

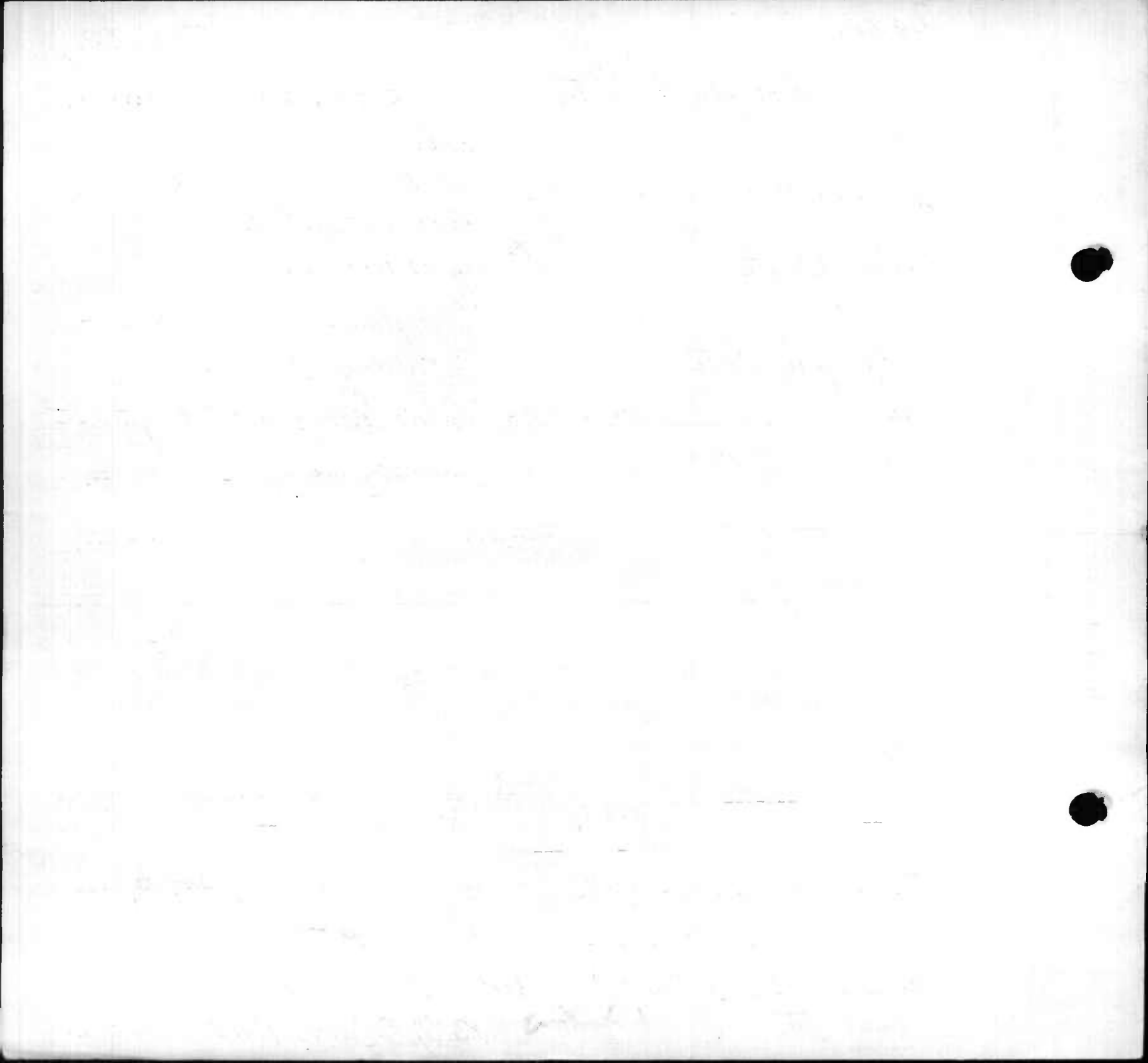
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07232 | |
|--|------------------|--|---------------------------------|--|---|
| P-362 72 07232 | | | | STATE OF MARYLAND - DMH | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Nancy Peterson | | 2. DATE AND HOUR OF DEATH 7/31/72 10:18 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 18 Maryland General Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY ANNE ARUNDEL C. CITY OR TOWN Severn D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Box 240, Old Oak Rd. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/19/55 | | 9. AGE (In years last birthday) 17 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student | | 10B. KIND OF BUSINESS OR INDUSTRY SPECIAL EDUCATION | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? US | | 13. FATHER'S NAME Jacob Peterson | | | |
| 14. MOTHER'S MAIDEN NAME NANCY L. SNYDER | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT MRS. JACOB E. PETERSON (mother) Same As #4 | | | |
| 18. 582X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Chronic Renal failure DUE TO, OR AS A CONSEQUENCE OF: (B) Suspected chronic glomerulonephritis DUE TO, OR AS A CONSEQUENCE OF: 2 years (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Mental retardation APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH life | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from June 25, 1972 to July 31, 1972 that (I) (we) last saw the deceased alive on July 31, 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Donald T. Lewers M.D. | | 23B. DATE SIGNED July 31, 1972 | | 23C. PHYSICIAN'S NAME (Type) Donald T. Lewers, M.D. | |
| 23D. ADDRESS 827 Linden Avenue Baltimore, Maryland 21201 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE AUG 3/72 | | 24C. NAME OF CEMETERY or CREMATORY GLEN HAVEN MEMORIAL PARK | |
| 24D. LOCATION (City, town, or county) (State) GLEN BURNIE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | | |
| 25B. NAME OF REGISTRAR Anthony J. ... | | 25C. FUNERAL DIRECTOR ... | | | |
| 25D. ADDRESS SINGLETON FUNERAL HOME GLEN BURNIE, MD. | | | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07233 | |
|---|---------|--|------------------------------|---|---|
| 72 07233 | | | | STATE OF MARYLAND | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Joseph J. Petr | | July 28, 1972 9:10 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | |
| Armcast Nursing Home Inc | | | | Md. 2632 | |
| | | | | C. CITY OR TOWN D. INSIDE CITY LIMITS? | |
| | | | | Balto. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER | |
| | | | | 4809 Althea Ave | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| Male | White | | Aug. 31 1887 | 84 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| ? | | ? | | Snowland | |
| 13. FATHER'S NAME | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Joseph Petr | | | U. S. A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 216-09-7223A | | J. Calvin Carney 3 E Lexington St | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES | | | | Arteriosclerotic cardio-vascular disease 10 yrs. | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) Epilepsy 10 yrs. | |
| | | | | (C) _____ | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 19 72 to July 28 19 72 that (I) (we) last saw the deceased alive on July 9, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Lloyd E. Saylor, M.D. | | | | July 31, 1972 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Lloyd E. Saylor, M. D. | | | | 3902 Greenmount Avenue | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 8/1/72 | | Most Holy Redeemer | |
| | | | | Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| AUG 1 1972 | | Adrian W. Hyatt | | Philip B. Bach 1211 Chesaco Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07234 | |
|--|--|---|--|--|--|
| S-514 72 07234 | | | | STATE OF MARYLAND-DEME | |
| BIRTH NO. | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <i>Sample, EDWARD ELSTON</i> | | 2. DATE AND HOUR OF DEATH <i>July 30, 1972 9:30 A.M.</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>HARFORD</i> | | | |
| 5. SEX <i>M</i> 6. RACE <i>W</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>8-22-45</i> | | 9. AGE (In years last birthday) <i>26</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MACHINE OPERATOR</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>SHOE MANUFACTURE</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i> | |
| 13. FATHER'S NAME <i>Everett William Sample</i> | | 14. MOTHER'S MAIDEN NAME <i>Marie York</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>216-44-4713</i> | | 17. INFORMANT (Mother) <i>838-3719</i> ADDRESS <i>1201 Prospect Mill Rd. Bel Air, Maryland 21014</i> | |
| 18. <i>E 814.71</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>MULTIPLE TRAUMA</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>CAR - Pedestrian Accident</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>ANOXIC ARREST</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <i>July 23, 1972</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>INTER-ADVENTUAL Bleeding</i> | | 20A. AUTOPSY? (Yes or No) <i>YES</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>DR. FISHER</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>STREET</i> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>Rt #1 1/2 N. South View Ct. Rt. 156</i> | |
| 21D. TIME OF INJURY (APPROX.) <i>July 22 1972 10:30 AM</i> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <i>CAR STRUCK Pedestrian (Patient)</i> | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>July 22nd</i> 19 <i>72</i> to <i>July 30</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>July 30</i> 19 <i>72</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Willie B. Long M.D.</i> | | 23B. DATE SIGNED <i>July 30, 1972</i> | | 23C. PHYSICIAN'S NAME (Type) <i>Willie B. Long M.D.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>Aug. 1, 1972</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Bel Air Memorial Gardens</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Bel Air, Harford Co., Maryland 21014</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>AUG 1 1972</i> | | 25B. NAME OF REGISTRAR <i>Arlene L. Foster</i> | |
| 25C. FUNERAL DIRECTOR <i>Joseph Williams & Son</i> | | 25D. ADDRESS <i>W. Broadway & Williams St. Bel Air, Maryland 21014</i> | | 25E. ADDRESS <i>Bel Air, Maryland 21014</i> | |

Page 10 of 10

12

1. The first part of the document is a list of names and addresses of the members of the committee.

13

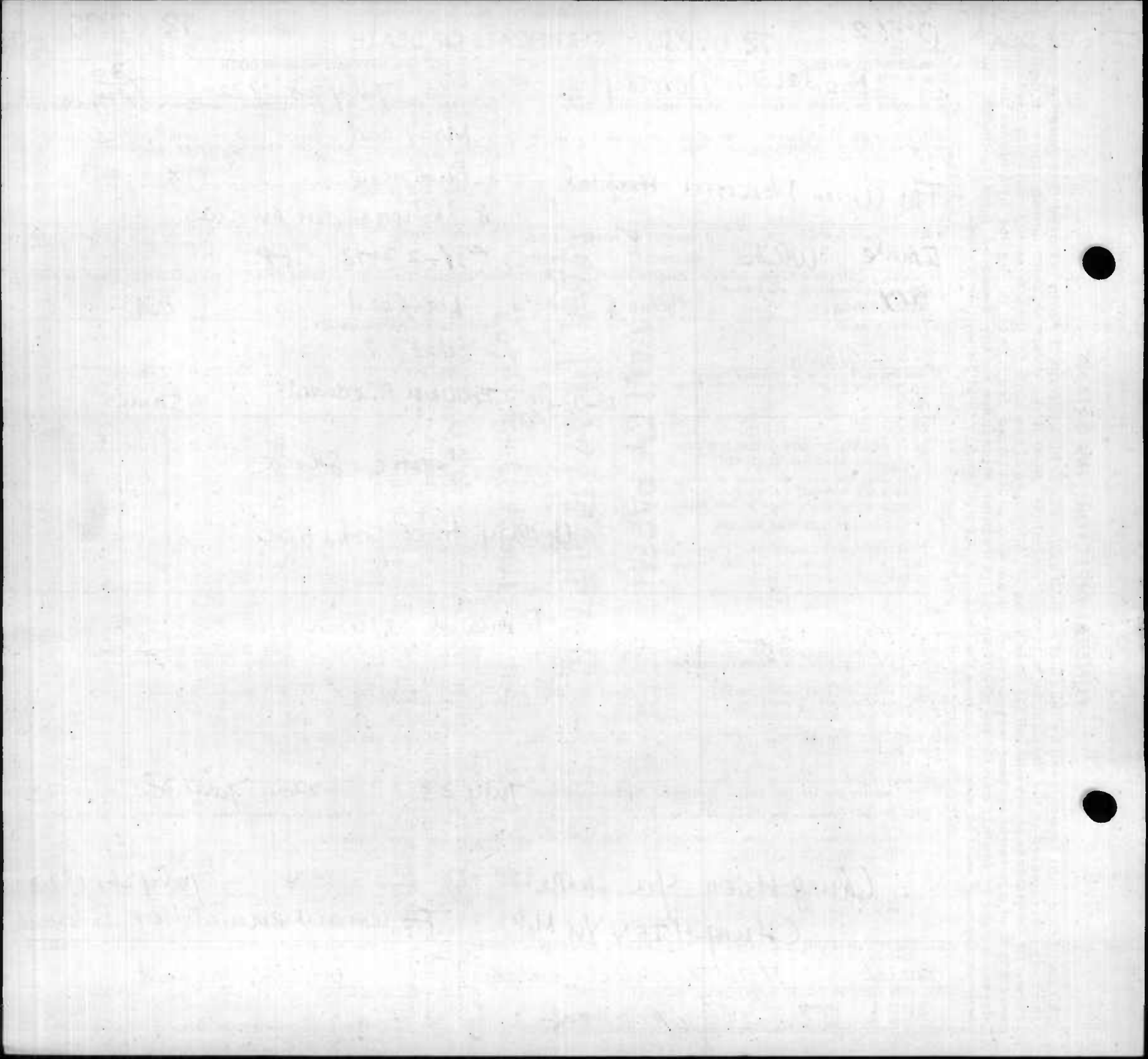
2. The second part of the document is a list of names and addresses of the members of the committee.

3. The third part of the document is a list of names and addresses of the members of the committee.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07235 | |
|--|-------------------------|---|-------------------------------------|---|--|
| B-362 72 07235 | | | | STATE OF MARYLAND-DHMH | |
| BIRTH NO. | | | | DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Bioderski, Dorothy E. | | | | 2. DATE AND HOUR OF DEATH July 28 1972 30 PM M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission) A. STATE Maryland B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Union Memorial Hospital | | | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER 836 Dumbarton Avenue | | | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-22-13 | | 9. AGE (In years last birthday) 58 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress | | 10B. KIND OF BUSINESS OR INDUSTRY "eloe & Jewel's" | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 13. FATHER'S NAME - Gibson | | | | 14. MOTHER'S MAIDEN NAME Ethel ? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 278-03-0537 | | 17. INFORMANT Edward Bioderski | |
| | | | | ADDRESS Same. | |
| 18. 599.01 | | | | CAUSE OF DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE Septic shock DUE TO, OR AS A CONSEQUENCE OF: | |
| | | | | (B) Urinary tract infection DUE TO, OR AS A CONSEQUENCE OF: | |
| | | | | (C) _____ | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Bronchial asthma | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 23 19 72 to July 28 19 72 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Chung-Hsien Yu, M.D. | | | | 23B. DATE SIGNED July 28, 1972 | |
| 23C. PHYSICIAN'S NAME (Type) CHUNG-HSIEN YU, M.D. | | | | 23D. ADDRESS The Union Memorial Hosp, Baltimore | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/31/72 | | 24C. NAME OF CEMETERY OR CREMATORY Bethel Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Windfield, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | 25B. NAME OF REGISTRAR Sidney Whitton | | 25C. FUNERAL DIRECTOR John A. Moran, Inc. | |
| ADDRESS 3300 E. Baltimore St. Baltimore, Md. 21224 | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07236 | |
|---|---------------|--|---|---|-------------------------------------|
| 72 07236 | | | | STATE OF MARYLAND-DHMA | |
| BIRTH NO. 10-420 | | | | DATE AND HOUR OF DEATH 7/27/72 9:30 P. | |
| 1. NAME OF DECEASED (Type or Print) WELSH, MARVIN WILLIAM | | | | 2. DATE AND HOUR OF DEATH 7/27/72 9:30 P. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BLVD BALTIMORE, MARYLAND 21218 | | | | C. CITY OR TOWN GLEN BURNIE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| E. STREET AND NUMBER 18 Sumac Road | | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-6-11 | 9. AGE (In years last birthday) 60 | 10. AGE (In years last birthday) 60 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GUARD | | | 11. BIRTHPLACE (State or foreign country) ROANOKE RAPIDS, N. C. | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME CHARLES Welsh | | | 14. MOTHER'S MAIDEN NAME EFFIE SMALLWOOD | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 2-11-39-10-16-45 | | | 16. SOCIAL SECURITY NO. 167-16-92-60 | | |
| 17. INFORMANT CLINICAL RECORDS-VAH BALTO MD. | | | ADDRESS 21218 | | |
| 18. 43201 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio-Pulmonary Dysfunction 5 days (B) Cerebrovascular Accident 4 months (C) Left Carotid Stenosis 5 months | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Hypertension | | | | | |
| 19A. DATE OF OPERATION 7/20/72 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED mild right hemiparesis with mental slowness | | 20A. AUTOPSY? (Yes or No) NONE | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from 7/14 19 72 to 7/27/ 19 72, that (X) (we) last saw the deceased alive on 7/27/ 19 72 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Katsuzo Fujita | | | | 23B. DATE SIGNED 7/28/72 | |
| 23C. PHYSICIAN'S NAME (Type) KATSUZO FUJITA, M. D. | | | | 23D. ADDRESS VA Hospital, Baltimore, Md. 21218 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 31 July 72 | | 24C. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park | |
| 24D. LOCATION (City, town, or county) (State) Md. | | 24E. LOCATION (City, town, or county) (State) Md. | | 24F. LOCATION (City, town, or county) (State) Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS Kirkley Funeral Home, Glen Burnie, Md. 21061 | |

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1. 1000000 2. 1000000 3. 1000000 4. 1000000 5. 1000000 6. 1000000 7. 1000000 8. 1000000 9. 1000000 10. 1000000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | X | | STATE OF MARYLAND - DEPT | |
|--|--|---|--|---|--|---|--|
| BIRTH NO. A-652 | | | | 72 07237 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | |
| ARRINGTON EDWARD HERMAN | | | | 07/25/72 | | 7:20AM M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Carroll | | 5. CITY OR TOWN SYKESVILLE | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | E. STREET AND NUMBER ARRINGTON ROAD 21784 | |
| 5. SEX MALE | | 6. RACE CAUCASIAN | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11/29/06 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR | | 10B. KIND OF BUSINESS OR INDUSTRY Pole Line Cont. | | 9. AGE (In years last birthday) 65 | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME ALBERT F. ARRINGTON, A. Frank | | | | 14. MOTHER'S MAIDEN NAME MARGARET (HUSSELBAUGH) | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 216 32 7938 | | 17. INFORMANT ADDRESS ST AGNES HOSPITAL BALTO MD 21229 | |
| 18. 44111 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CORDIAL TAMPONADE | | | | CAUSE OF DEATH Rupture aneurysm of ascending aorta | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 d. 2 d. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | ASCVD - Hypertension Systemic | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (X) (this hospital) attended the deceased from 07/21/72 19 to 07/25/72 19 | | that (X) (we) last saw the deceased alive on 07/25/72 19 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE [Signature] | | | | 23B. DATE SIGNED 07/25/72 | | 23C. PHYSICIAN'S NAME (Type) APTER, JOSE MD | |
| 23D. ADDRESS ST AGNES HOSPITAL BALTO MD 21229 | | | | 23E. ATTENDING PHYSICIAN <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23F. ADDRESS ST AGNES HOSPITAL BALTO MD 21229 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-28-72 | | 24C. NAME OF CEMETERY or CREMATORY Lake View Cemetery | | 24D. LOCATION (City, town, or county) (State) Sykesville Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | 25B. NAME OF REGISTRAR [Signature] | | 25C. FUNERAL DIRECTOR [Signature] | | 25D. ADDRESS [Signature] | |

12-2-42

1:50 PM

CLINICAL

ST. ALBANS HOSPITAL

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ST. ALBANS HOSPITAL

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RECEIVED

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ST. ALBANS HOSPITAL

ST. ALBANS HOSPITAL

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RECEIVED

CLINICAL

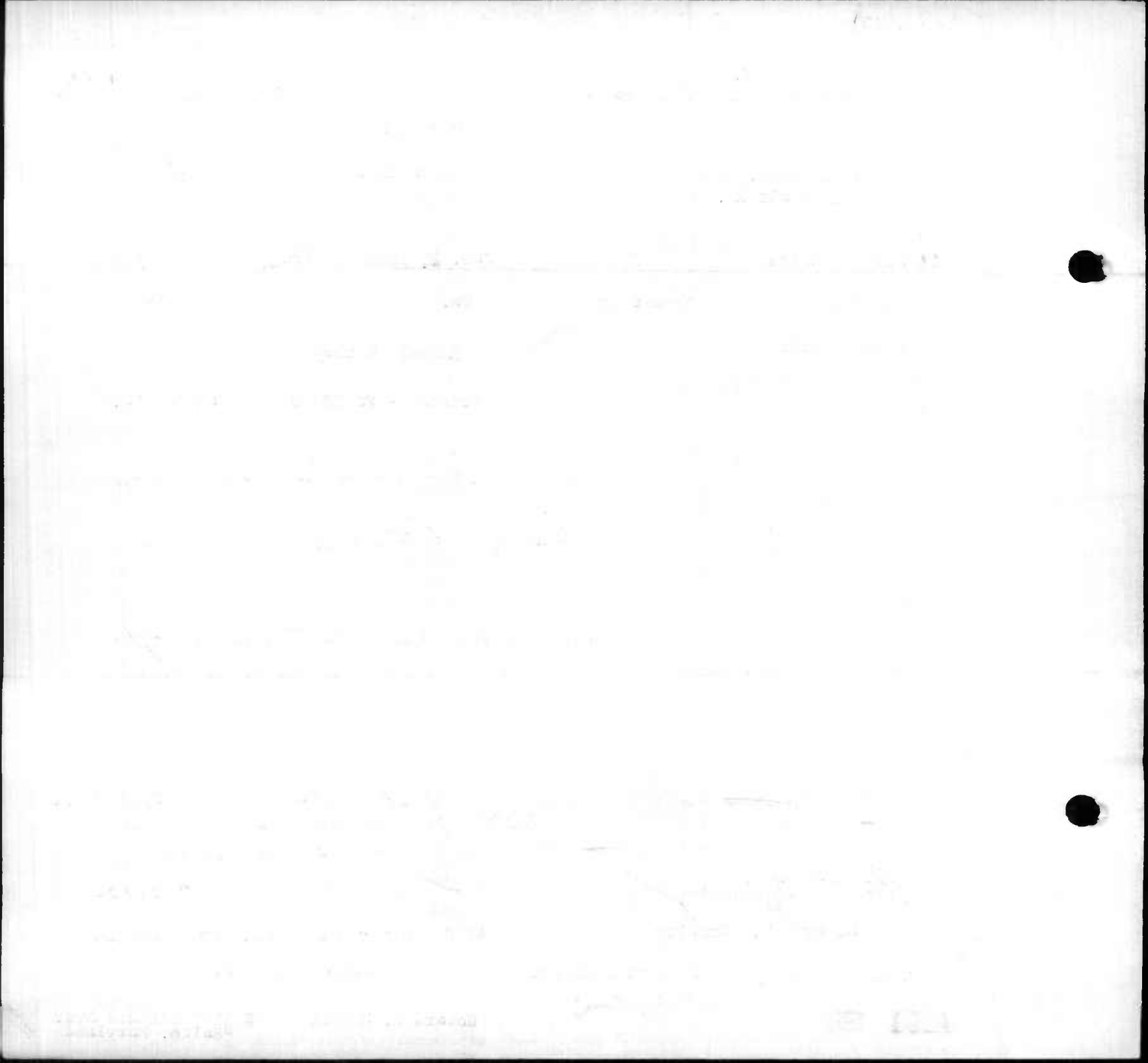
12-2-42

ST. ALBANS HOSPITAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| C-450 72 07238 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 72 07238 |
|---|-------------------------|--|---|---|
| 1. NAME OF DECEASED (Type or Print) OLA COLONNA | | 2. DATE AND HOUR OF DEATH 7/29/72 3:30 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Gould Conv. Home 6116 Blair Rd. | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Virginia B. COUNTY V43 C. CITY OR TOWN Deltaville D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 2, 1881 | 9. AGE (In years, last birthday) 91 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Homemaker | | 11. BIRTHPLACE (State or foreign country) Va. |
| 13. FATHER'S NAME Samuel Norris | | 14. MOTHER'S MAIDEN NAME Rachel Hurley | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Bristow - Faulkner ADDRESS Saluda, Va. |
| 18. 412.3 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Public "Little Sister" ; Renter Dyspepsia | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (the doctor) attended the deceased from 7/12/1972 to 7/29/1972 that (I) (we) last saw the deceased alive on 7/27/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. BY 10 MINUTES | | | | |
| 23A. SIGNATURE Albert B. Bradley | | 23B. DATE SIGNED 7/29/72 | | 23C. PHYSICIAN'S NAME (Type) Albert B. Bradley |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE July 31, 72 | | 24C. NAME OF CEMETERY OR CREMATORY Norris Cemetery |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | 25B. NAME OF REGISTRAR Lindsey | | 25C. FUNERAL DIRECTOR Howard H. Hubbard ADDRESS 4107 Wilkens Ave. Balto. Maryland |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07239 | |
|--|--|--|--|--|---|
| 4-635 | | | | 72 07239 | |
| BIRTH NO. | | | | STATE OF MARYLAND-DEMD | |
| 1. NAME OF DECEASED (Type or Print) HARTMAN, ALBERT | | | 2. DATE AND HOUR OF DEATH 7/29/72 at 8:15 AM | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 SOUTH BALTIMORE GENERAL HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL | | |
| | | | C. CITY OR TOWN Glen Burnie, MD. | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 5. SEX Male 6. RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH 5-6-1895 | | 9. AGE (In years last birthday) 77 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED. | | | 10B. KIND OF BUSINESS OR INDUSTRY U.S. COAST GUARD | | 11. BIRTHPLACE (State or foreign country) MARYLAND. |
| 12. CITIZEN OF WHAT COUNTRY? USA. | | | 13. FATHER'S NAME ALBERT HARTMAN | | |
| 14. MOTHER'S MAIDEN NAME KATHERINE ROKOWSKY | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW I | | |
| 16. SOCIAL SECURITY NO. 216.10.3693 | | | 17. INFORMANT MARIE C. HARTMAN (wife) SAME AS # 4 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arterio stenosis | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH - | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost. | | | (A) IMMEDIATE CAUSE Generalized arteriosclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: HYPERTENSIVE DIATHESIS (C) Pulmonary edema | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES. | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11:00 AM 7-14-1972 to 7:29 AM 7-29-1972 that (I) (we) last saw the deceased alive on 7:29 AM 7-29-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE My int. ALBIS, MD. | | | 23B. DATE SIGNED 7-29-72 | | |
| 23C. PHYSICIAN'S NAME (Type) DR. THAN MYINT. | | | 23D. ADDRESS S.B.G.H. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) ENTOMBMENT | | 24B. DATE AUG. 2/72 | | 24C. NAME of CEMETERY or CREMATORY LORRAINE PARK MAUSOLEUM | |
| 24D. LOCATION BALTIMORE, MARYLAND | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | 25B. NAME of REGISTRAR B. J. Z... | | 25C. FUNERAL DIRECTOR SINGLETON FUNERAL HOME | |
| | | | | GLEN BURNIE, MARYLAND | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 72 07240 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | REG. NO. 72 07240 | |
|---|---------------------|---|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) <i>Sigley, Jessie</i> | | | | 2. DATE AND HOUR OF DEATH <i>7-29-72</i> <i>1:50 A.M.</i> | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Bolton Hill Nursing Home</i> | | | | A. STATE <i>Maryland</i> | | B. COUNTY <i>Anne Arundel</i> | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>1400 John St.</i> | | | | C. CITY OR TOWN <i>Odenton</i> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| E. STREET AND NUMBER <i>453 Oakton Road</i> | | | | | | | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>10-23-08</i> | 9. AGE (In years last birthday) <i>63</i> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife (ret.)</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>own home</i> | | 11. BIRTHPLACE (State or foreign country) <i>West Virginia</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>George Hartley</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Ada Gibson</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | | | 16. SOCIAL SECURITY NO. <i>231-12-0954</i> | | 17. INFORMANT <i>Mrs. Betty Jean Hood</i> | | ADDRESS <i>Same As #4</i> | |
| 18. <i>486X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Pneumonitis</i> | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pneumonitis</i> | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Parkinsons Disease</i> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>several days</i> | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nally medical examined) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>8-13-71</i> to <i>7-29-72</i> that (I) (we) last saw the deceased alive on <i>7-29-72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>E. Ellsworth Cook MD</i> | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>7-29-72</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>E. Ellsworth Cook MD</i> | | | | 23D. ADDRESS <i>2431 Maryland Ave.</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>Aug. 2/72</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Mount Isreal</i> | | 24D. LOCATION (City, town, or county) (State) <i>Preston County, W. Va.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>AUG 1 1972</i> | | | | 25B. NAME OF REGISTRAR <i>Frederick J. ...</i> | | 25C. FUNERAL DIRECTOR <i>R. ...</i> | | | |
| ADDRESS <i>Singleton Funeral Home Glen Burnie, Md.</i> | | | | | | | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|--|--|--|--|--|--|--|
| S-600 | | 72 07241 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07241 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | REG. NO. | |
| | | SAWYER, CLIFTON ALBERT, JR. | | JULY 29, 1972 | | 2:00A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE | | B. COUNTY | |
| 40 | | ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229 | | MARYLAND | | ANNE ARUNDEL 21122 | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| MALE | | CAUCASIAN | | 05/10/18 | | 54 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| STOCK CLERK | | | | AUTO PARTS | | MARYLAND | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| CLIFTON SAWYER | | | | LILLIAN BAILEY | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| YES | | | | 218-10-2881 | | BALTO MD 21229 ST AGNES' RECORDS CATON & WILKENS AVES | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | pulmonary edema | | | |
| ANTECEDENT CAUSES | | | | Hypertensive cardiovascular disease | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | | | YES | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (X) (this hospital) attended the deceased from JULY 21 19 72 to JULY 29 19 72, that (X) (we) last saw the deceased alive on JULY 29 19 72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) | |
| Vincent H. Wang, MD | | | | 07 29 72 | | VINCENT H. WANG, M.D. | |
| 23D. ADDRESS | | | | 23E. ADDRESS | | | |
| BALTIMORE, MD. 21229 | | | | ST. AGNES HOSPITAL-CATON & WILKENS AVES. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | | AUG. 1/72 | | HOLLY HILL MEM. GARD. | | WHITEMARSH, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | |
| AUG 1 1972 | | Sidney H. Brown | | B. K. K. K. | | SINGLETON FUNERAL HOME GLEN BURNIE, MD. | |

1:00 PM

JULY 20, 1952

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|----------------------|---|---|--|---|
| BIRTH NO. 11-422 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07242 | |
| 1. NAME OF DECEASED (Type or Print) WILCZEK, TEDDY JOHN | | | 2. DATE AND HOUR OF DEATH JULY 25, 1972 10:25 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 422 SOUTH AUGUSTA AVENUE 21229 | | |
| 5. SEX MALE | 6. RACE CAUCASIAN | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 07 03 32 | 9. AGE (In years last birthday) 40 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SERVICEMAN | | 10B. KIND OF BUSINESS OR INDUSTRY ARMY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME THAD IUS WILCZEK | | 14. MOTHER'S MAIDEN NAME GRACE MILLER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES KOREA | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT BALTIMORE MARYLAND 21229 ST AGNES HOSPITAL CATON & WILKENS AVE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 HRS. UNKNOWN UNKNOWN | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JULY 25 19 72 to JULY 25 19 72, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on JULY 25 19 72 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death. | | | | | |
| 23A. SIGNATURE Robert W. Ashmore MD OEGREE | | | | 23B. DATE SIGNED 7/26/72 | |
| 23C. PHYSICIAN'S NAME (Type) ROBERT W. ASHMORE, M.D. | | | | 23D. ADDRESS BALTIMORE MD 21229 ST AGNES HOSPITAL CATON & WILKENS AVE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/28/1972 | | 24C. NAME OF CEMETERY OR CREMATORY Glen Haven | |
| 24D. LOCATION Glen Burnie, Maryland | | 24E. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | 24F. NAME OF REGISTRAR G. Truman Schwab | |
| 24G. FUNERAL DIRECTOR G. Truman Schwab | | 24H. ADDRESS 3512 Frederick Ave. | | 24I. DATE AUG 1 1972 | |

10:30 AM

JULY 22, 1972

1700 17th St NW

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WILLIAM

ST JOHN HOSPITAL

100 SOUTH AUGUSTA AVENUE

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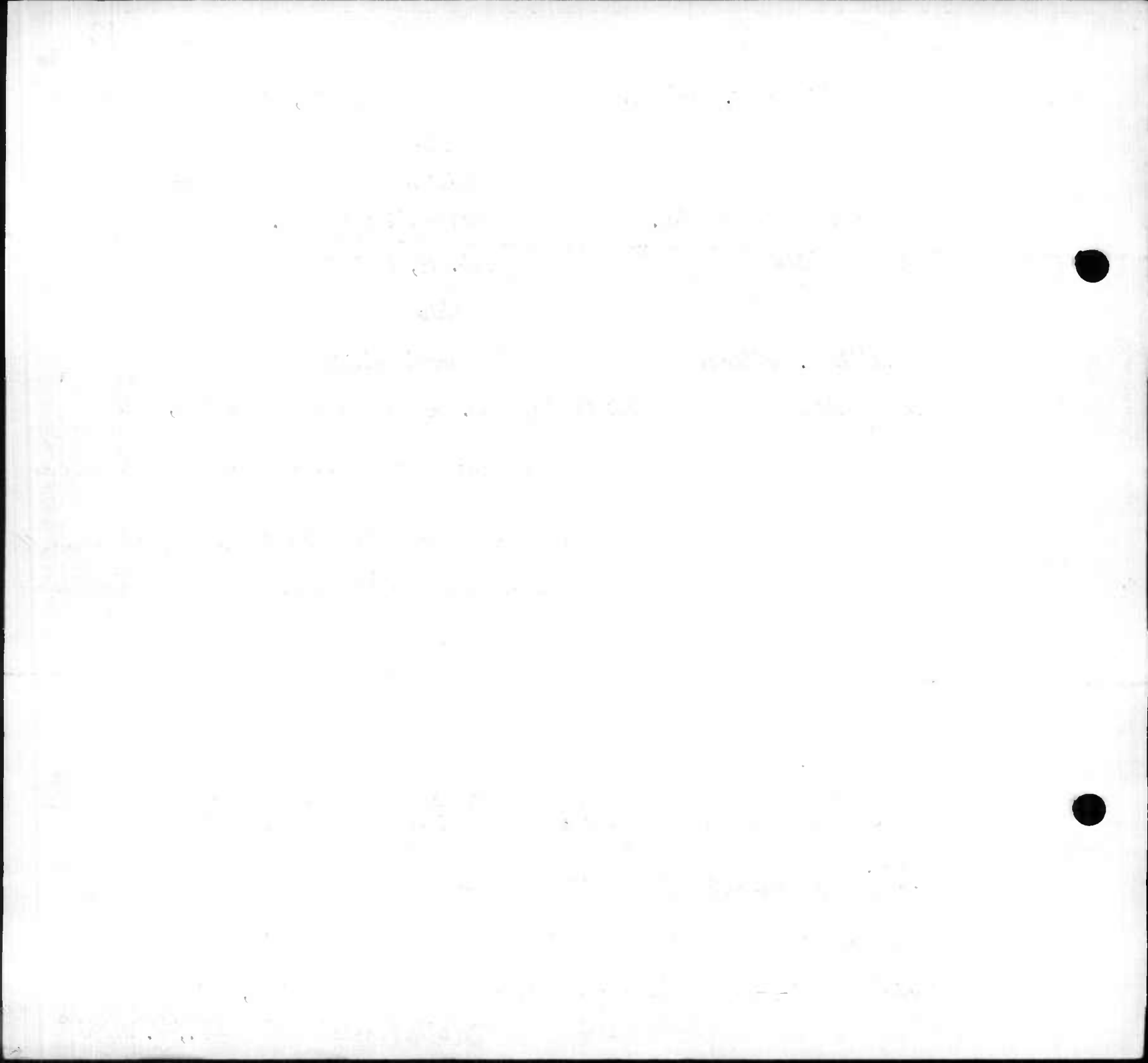
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ST JOHN HOSPITAL

ST JOHN HOSPITAL

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07243 | | 72 07243 | |
|---|-------------------------|---|--|--|--|--|--|
| 72 07243 | | | | 72 07243 | | 72 07243 | |
| 72 07243 | | | | 72 07243 | | 72 07243 | |
| BIRTH NO. <u>S-415</u> | | | | REG. NO. <u>72 07243</u> | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Virgil J. Sullivan</u> | | | | 2. DATE AND HOUR OF DEATH <u>July 29, 1972</u> <u>10. A. M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00</u> <u>681 Washington Blvd.</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2101</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>681 Washington Blvd.</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 19, 1925</u> | 9. AGE (In years last birthday) <u>47</u> | 10. Under 1 Yr. Months: Days: Hours: Min. | 11. Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Ohio</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Tillis A. Sullivan</u> | | | 14. MOTHER'S MAIDEN NAME <u>Hazel Pollitt</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW 2</u> | | | 16. SOCIAL SECURITY NO. <u>294 14 4489</u> | | 17. INFORMANT <u>Mrs. George Thomas</u> | | |
| | | | | | ADDRESS <u>Greenfield, Ohio</u> | | |
| 18. <u>250.9 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>myocardial Infarction</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic Heart Disease</u> (B) <u>15 months</u> <u>Diabetes Mellitus</u> (C) <u>11 years</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10/21</u> 19 <u>69</u> to <u>7/29</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>6/15</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>John P. Urlock Jr.</u> M.D. DEGREE | | | | 23B. DATE SIGNED <u>7/31/72</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>John P. Urlock Jr.</u> M.D. DEGREE | | | | 23D. ADDRESS <u>1227 WASH. BLVD BALTIMORE MD.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>8-3-72</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Greenfield Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Greenfield, Ohio</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 1 1972</u> | | 25B. NAME OF REGISTRAR <u>Lidny</u> | | 25C. FUNERAL DIRECTOR <u>McCall Funeral Home</u> | | ADDRESS <u>130 East Ford Avenue Balto., Md. 21230</u> | |



| STATE OF MARYLAND-DEME | | | | 72 07244 | | | |
|---|--|---|--|--|--|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07244 | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| BIRTH NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | MEYER DAVIDSON | | 2. DATE OF DEATH | | Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) | | 5711 Rusk Avenue | | 3. DATE PRONOUNCED DEAD | | Month Day Year Hour July 26, 1972 12:55 A.M. | |
| 6. SEX Male | | 7. RACE White | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2719 | |
| 9. DATE OF BIRTH 1/6/1901 | | 10. AGE (In years lost birthday) 60 71 | | 11. BIRTHPLACE (State or foreign country) NEW YORK, N. Y. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME ? | | 14. MOTHER'S MAIDEN NAME SOPHIA ? | | 15. STREET AND NUMBER 5711 Rusk Avenue | | 16. CITY OR TOWN Baltimore | |
| 17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 18. SOCIAL SECURITY NO. 212-34-8984 | | 19. INFORMANT | | ADDRESS | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHARMACIST | | 14B. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED | | 15. MOTHER'S MAIDEN NAME SOPHIA ? | | 16. CITY OR TOWN Baltimore | |
| 17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 18. SOCIAL SECURITY NO. 212-34-8984 | | 19. INFORMANT | | ADDRESS | |
| 14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 17. SOCIAL SECURITY NO. 212-34-8984 | | 18. INFORMANT | | ADDRESS | |
| 19. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | (C) | | | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) Yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | Marvin S. Platt, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED July 27, 1972 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 7/30/72 | | 24C. NAME of CEMETERY or CREMATORY BNAI JACOB | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | 25B. NAME OF REGISTRAR Sidney W. Houston | | 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | ADDRESS | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07245 | | 72 07245 | |
|--|-------------------------|---|--|---|--|---|--|
| BIRTH NO. | | | | 72 07245 | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) <u>Grossman William</u> | | | | 2. DATE AND HOUR OF DEATH <u>7/28/72</u> <u>17:30</u> P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL</u> <u>42</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2717</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2500 W. BELVEDERE AVENUE, APT. 211</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1-14-81</u> | 9. AGE (in years last birthday) <u>91</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>RETAIL</u> | | 11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>NORMAN GROSSMAN</u> | | | | 14. MOTHER'S MAIDEN NAME <u>RACHAEL ?</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>218-32-1786A</u> | | 17. INFORMANT ADDRESS <u>MR. ISADORE GROSSMAN, 3409 ROSEDALE ROAD #15</u> | | | |
| 18. CAUSE OF DEATH <u>437.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE <u>Aspiration</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Cerebral atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Syrs.</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION <u>7/28/72</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>72</u> to <u>July</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>7/28</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Lawrence Solomon</u> | | | | 23B. DATE SIGNED <u>7/28/72</u> | | 23C. PHYSICIAN'S NAME (Type) <u>DEGREE</u> | |
| 23D. ADDRESS <u>3600 Lochearn Dr.</u> | | | | 23E. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>7/30/72</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>OHEL YAKOV</u> | | 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 1 1972</u> | | 25B. NAME OF REGISTRAR <u>Sidney B. ...</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| B-622 | | 72 07246 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07246 | |
| BIRTH NO. | | 72 07246 | | | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| MAURICE BARSHACK | | | | JULY 27, 1972 | | 9:45 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 5702 OAKSHIRE ROAD | | | | A. STATE MARYLAND | | B. COUNTY 2713 | |
| (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER 1190 W. NORTHERN PKWY. #21210 | | | | | | | |
| 5. SEX MALE | | 6. RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8/20/1903 | |
| 9. AGE (In years last birthday) 68 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GENERAL MANGER | | 11. BIRTHPLACE (State or foreign country) RUSSIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME BENJAMIN BARSHACK | | | | 14. MOTHER'S MAIDEN NAME PEARL KLINE | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 820-02-1037 | | 17. INFORMANT ADDRESS MR. JACK BARSHACK, 1190 W. NORTHERN PKWY. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Mitral valve Cancer probably from pneumonia</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1962 to 7/27 1972, that (I) (we) last saw the deceased alive on 7/26 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Leonard Lister</i> | | | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) LEONARD LISTER | | | | | | 23D. ADDRESS 7111 PARK HEIGHTS AVENUE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 7/30/1972 | | 24C. NAME OF CEMETERY or CREMATORY CHIZUK AMUNO (ARLINGTON) | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | | | 25B. NAME OF REGISTRAR <i>Adrienne</i> | | 25C. FUNERAL DIRECTOR ADDRESS SQL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | |

1150 N. MONTGOMERY TRAIL, WILSON

U.S.A.

PHASE THREE

HOUSE STABLES

REPLACEMENT BARRACKS

GENERAL WORKS

1976

1976

1976

1976

STATE OF TEXAS

BALLTOWN

JULY 27, 1976

1150

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | REG. NO. 72 07247 | |
|--|---------|--|------------------|--|------------------------------|
| 72 07247 | | | | STATE OF MARYLAND - DHMH | |
| BIRTH NO. 11-624 | | 1. NAME OF DECEASED (Type or Print) <i>Samson Margolis</i> | | | |
| 2. DATE AND HOUR OF DEATH | | JULY 28, 1972 3:45 P. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| 6626 VINCENT LANE, APT. 201 | | MARYLAND | | BALTIMORE | |
| C. CITY OR TOWN | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER | | 6626 VINCENT LANE, APT. 201 | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| MALE | WHITE | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 12/10/1897 | 74 | USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| PRINTER | | SELF EMPLOYED | | RUSSIA | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| ABRAHAM J. MARGOLIS | | RACHAEL ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 214-20-4115 | | MRS. MINNIE MARGOLIS, 6626 VINCENT LANE #15 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | D, Huse carcinomatosi | | | |
| ANTECEDENT CAUSES | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | Two separate colonic malignancies | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 19A. 1/1/72 | | 19B. Intraabdominal malignancy | | 20A. YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 21D. 1972 | | 21E. While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. 1972 | |
| 22. I certify that (I) this hospital attended the deceased from 1970 to July 28, 1972, that (I) we last saw the deceased alive on July 28, 1972 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| <i>Samson Margolis</i> | | | | 7/28/72 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| SEYMOUR H. RUBIN, M.D. | | 5415 Park Heights Ave | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| BURIAL | | 7/30/72 | | CHIZUK AMUNO (ARLINGTON) | |
| 24D. LOCATION | | BALTIMORE, MARYLAND | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| AUG 1 1972 | | <i>Samson Margolis</i> | | SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07248 | | 72 07248 | |
|--|--|--|--|--|--|--|--|
| BIRTH NO. | | | | K-240 | | 72 07248 | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | STATE OF MARYLAND-DHMH | |
| XXXXXXXXXX GERTRUDE KESSEL | | | | 7/30/72 | | 8:30 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE | | B. COUNTY | |
| SINAI HOSP. & BALTIMORE | | | | MD | | BALTO | |
| 5. SEX | | | | 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| FEMALE | | | | WHITE | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH | |
| HOUSEWIFE | | | | AT HOME | | 09/XXXXXX | |
| 11. BIRTHPLACE (Solo or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | 9. AGE (In years last birthday) | |
| LITHUANIA | | | | USA | | 74 | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | |
| ISADORE HURWITZ | | | | CHIA ? | | NO | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | ADDRESS | |
| 218-03-3865 | | | | MISS | | MRS. MARY KESSEL, 4333 CREST HIGHTS. RD. #21215 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE | | | |
| ANTECEDENT CAUSES | | | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DIABETES MELLITUS | | | |
| | | | | (C) | | | |
| II | | | | Disseminated Intravascular Coagulation | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | NO | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from | | | | 7/13 | | 1972 to 7/30/1972 | |
| that (I) (we) last saw the deceased alive on | | | | 19 | | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| MIHAS AMASTASIOS | | | | 7/30/72 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| BURIAL | | | | 7/31/72 | | BETH ISAAC ADATH ISRAEL | |
| 24D. LOCATION (City, town, or county) | | | | 24E. FUNERAL DIRECTOR | | ADDRESS | |
| BALTIMORE, MARYLAND | | | | SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| AUG 1 1972 | | | | SOL LEVINSON & BROS. | | 6010 REISTERSTOWN ROAD | |

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07249

BIRTH NO.

| | | | |
|---|-------------------------|---|--|
| 1. NAME OF DECEASED (Type or Print) ROBERT HENRY HABELSON | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 1701 Russell St. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 29 1972 1:25p M. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY BALTO | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 6. SEX male | 7. RACE white | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH JULY 4, 1900 | | 10. AGE (In years last birthday) 72 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN | | 14B. KIND OF BUSINESS OR INDUSTRY HOUSEWARE | |
| 15. MOTHER'S MAIDEN NAME LENA SIEGEL | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | |
| 17. SOCIAL SECURITY NO. 216-03-7607 | | 18. INFORMANT ADDRESS MRS. HATTIE HABELSON, 217 SUDBROOK LANE #21208 | |
| 19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22D. TIME (Month) (Day) (Year) (Hour) (Approx.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. DATE SIGNED 7-30-72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 7/31/72 | |
| 24C. NAME OF CEMETERY or CREMATORY MIKRO KODESH | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | 25B. NAME OF REGISTRAR Sidney M. ... | |
| 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | ADDRESS | |

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JULY 4, 1907

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WILLIAM JACOB HARRISON

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BALTIMORE, MARYLAND

JOHN SIBEL

WISCONSIN

SALISBURY

116-03-1007 188, WALTER HARRISON, 217 S. BROADWAY, NEW YORK

NO

WALTER HARRISON

WILLIAM J. HARRISON, N.Y.

BALTIMORE, MARYLAND

WILLIAM JACOB HARRISON

116-03-1007

SERIAL

JOHN SIBEL & SONS, 200 N. BROADWAY, NEW YORK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|------------------------------------|---|---|
| H-415 72 07250 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07250 | |
| BIRTH NO. | | REG. NO. | | STATE OF MARYLAND-DHMH | |
| 1. NAME OF DECEASED (Type or Print) <i>Marguerite Hilbinger</i> | | 2. DATE AND HOUR OF DEATH <i>7-29-72</i> <i>1 45 AM</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2706</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Edgewood Nursing Home</i> <i>6000 Bellona Ave., Balto. Md.</i> | | C. CITY OR TOWN <i>Baltimore</i> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <i>2717 Louise Avenue</i> | | | |
| 5. SEX <i>female</i> | 6. RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>12-4-94</i> | 9. AGE (In years last birthday) <i>77</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | | |
| 13. FATHER'S NAME <i>John V. Vorsteg</i> | | 14. MOTHER'S MAIDEN NAME <i>Mollie Hays</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <i>No</i> | | 16. SOCIAL SECURITY NO. <i>163-09-4445B</i> | | 17. INFORMANT ADDRESS <i>Edgewood Nursing Home, 6000 Bellona Av.</i> | |
| 18. <i>436.9</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Cerebral Vascular Accident</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Age</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>PARKINSON DISEASE</i> | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (if in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>7/28/72</i> to <i>7/29/72</i> and that (I) (we) last saw the deceased alive on <i>7/28/72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Anthony F. Parozza</i> | | 23B. DATE SIGNED <i>7/30/72</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>Anthony F. Parozza</i> | | 23D. ADDRESS <i>5217 York Rd Balto Md 21212</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>8/1/72</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>St. John's Lutheran Cemetery</i> | |
| 24D. LOCATION (City, town, or county) <i>Balto.</i> | | 24E. (State) <i>Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>AUG 1 1972</i> | | 25B. NAME OF REGISTRAR <i>Sidney [illegible]</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Lassahn Funeral Home 7401 Belair Rd, Balto. 21236</i> | |

Subway

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07251 | |
|--|--|---|---|--|---|
| BIRTH NO. 72 07251 | | | | STATE OF MARYLAND-DHMH | |
| 1. NAME OF DECEASED (Type or Print) <i>William E. Moltz</i> | | | 2. DATE AND HOUR OF DEATH <i>July 31, 1972</i> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>00 3613 Hudson St.</i> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>2609</i> | | |
| 5. SEX <i>M</i> 6. RACE <i>W</i> | | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>1-24-1915</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Bethlehem Shipyard</i> | | 11. BIRTHPLACE (State or foreign country) <i>Md.</i> |
| 13. FATHER'S NAME <i>Wm. Moltz</i> | | | 14. MOTHER'S MAIDEN NAME <i>Mary Spangler</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | 16. SOCIAL SECURITY NO. <i>217-03-68779</i> | | 17. INFORMANT <i>Amelia H. Moltz</i> |
| 18. <i>753.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Coronary Insufficiency</i> | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Uremia</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Polycystic Kidney</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 weeks</i> <i>Life</i> <i>?</i> |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Feb. 6</i> 1970 to <i>July 31</i> 1972, that (I) (we) last saw the deceased alive on <i>July 27</i> 1972 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was did (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Susan H. Gaskel M.D.</i> | | | | 23B. DATE SIGNED <i>July 31, 1972</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Jason H. Gaskel, M.D.</i> | | | | 23D. ADDRESS <i>437 S. Conkling St. Baltimore, Md.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>8-3-72</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>AUG 1 1972</i> | | 25B. NAME OF REGISTRAR <i>Sidney Johnston</i> | | 25C. FUNERAL DIRECTOR <i>Helmut Hoffmann</i> | |
| | | | | ADDRESS <i>3218 Hudson St.</i> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|-----------------------------|---|--|
| <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p> | | <p>REG. NO. 72 07252</p> <p>STATE OF MARYLAND - DEPT. OF HEALTH</p> | |
| <p>BIRTH NO. G-246</p> | | <p>BALTIMORE CITY HEALTH DEPARTMENT</p> | |
| <p>1. NAME OF DECEASED (Type or Print) BABY BOY GIESLER,</p> | | <p>2. DATE AND HOUR OF DEATH 07-22-72 4:15 P</p> | |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD THE JOHNS HOPKINS HOSPITAL</p> | | <p>4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE</p> | |
| <p>FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL</p> | | <p>C. CITY OR TOWN JOPPA D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> | |
| <p>IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION</p> | | <p>E. STREET AND NUMBER 120 OLD CHURCH DR.</p> | |
| <p>5. SEX MALE</p> | <p>6. RACE WHITE</p> | <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> | <p>8. DATE OF BIRTH 7-22-72</p> |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None</p> | | <p>11. BIRTHPLACE (State or foreign country) Baltimore</p> | |
| <p>10B. KIND OF BUSINESS OR INDUSTRY None</p> | | <p>12. CITIZEN OF WHAT COUNTRY? USA</p> | |
| <p>13. FATHER'S NAME THOMAS GIESLER,</p> | | <p>14. MOTHER'S MAIDEN NAME ALICE GALL</p> | |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None</p> | | <p>16. SOCIAL SECURITY NO. None</p> | |
| <p>17. INFORMANT Thomas Giesler</p> | | <p>ADDRESS Joppa, Md.</p> | |
| <p>18. 746.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACIDOSIS, SHOCK, ASYSTOLE</p> | | <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 h.</p> | |
| <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CONGENITAL HEART DISEASE</p> | | <p>(B) DUE TO, OR AS A CONSEQUENCE OF: 1 d.</p> | |
| <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). R/O RENAL DISEASE</p> | | <p>(C) DUE TO, OR AS A CONSEQUENCE OF: None</p> | |
| <p>19A. DATE OF OPERATION None</p> | | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None</p> | |
| <p>20A. AUTOPSY (Yes or No) YES</p> | | <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? None</p> | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p> | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None</p> | |
| <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None</p> | | <p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) None</p> | |
| <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | | <p>21F. HOW DID INJURY OCCUR? None</p> | |
| <p>22. I certify that (I) (this hospital) attended the deceased from 22 July 72 2 PM to 22 July 72 4:15 PM that (I) (we) last saw the deceased alive on 22 July 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | | | |
| <p>23A. SIGNATURE Stanley A. Cohen MD</p> | | <p>23B. DATE SIGNED 22 July 72</p> | |
| <p>23C. PHYSICIAN'S NAME (Type) STANLEY A. COHEN</p> | | <p>23D. ADDRESS M.D. 607 N. BROADWAY BALTIMORE, MD.</p> | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p> | | <p>24B. DATE July 24/72</p> | |
| <p>24C. NAME OF CEMETERY OR CREMATORY Burial Oak Lawn</p> | | <p>24D. LOCATION (City, town, or county) (State) Baltimore Md.</p> | |
| <p>25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972</p> | | <p>25B. NAME OF REGISTRAR Sidney Houston</p> | |
| <p>25C. FUNERAL DIRECTOR John Henry</p> | | <p>ADDRESS 4106 E Northham</p> | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| S-535 | | 72 07253 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07253 | |
|---|------------------|---|--|--|---|---|----------------------------------|
| BIRTH NO. | | | | STATE OF MARYLAND - DIME | | | |
| 1. NAME OF DECEASED (Type or Print) SHENTON, WILLIAM. F. | | | | 2. DATE AND HOUR OF DEATH 5:30 PM, 7.25.72. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL. | | | | A. STATE Md. U.S.A. | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 44 | | | | E. STREET AND NUMBER 5321 BRABANT RD. BALTIMORE, MD, 21229 | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8/2/93. | 9. AGE (In years last birthday) 78 years | 10. If Under 1 Yr. Months: Days: Hours: Min. | 11. If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Office work. Laundry | | | | 10B. KIND OF BUSINESS OR INDUSTRY Laundry | | 11. BIRTHPLACE (State or foreign country) MARYLAND. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME James F. SHENTON. | | | |
| 14. MOTHER'S MAIDEN NAME FANNIE TAYLOR. | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. 215-05-3213 | | | | 17. INFORMANT A. CHART | | | |
| 18. 342 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Parkinson disease secondary to arteriosclerotic arteriosclerotic vascular disease (B) DUE TO, OR AS A CONSEQUENCE OF: with urinary tract infection (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 20A. AUTOPSY? (Yes or No) | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (H) (this hospital) attended the deceased from June 27 1972 to July 25 1972, that (H) (we) last saw the deceased alive on July 25 1972 and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE M. Shocair | | | | 23B. DATE SIGNED 7.25.72 | | | |
| 23C. PHYSICIAN'S NAME (Type) M. SHOCAIR Mawya MD. | | | | 23D. ADDRESS UNION MEMORIAL HOSPITAL - Baltimore Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 7/28/1972 | | | |
| 24C. NAME OF CEMETERY OR CREMATORY Loudon Park | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | | | 25B. NAME OF REGISTRAR Dorothy H. Heston | | | |
| 25C. FUNERAL DIRECTOR G. Truman Schwab | | | | 25D. ADDRESS 5151 Balto. Nat'l. Pike | | | |

712812912 Boston Park
Baltimore, Maryland
P. O. Box 10000
Baltimore, Maryland

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07254

BIRTH NO.

| | | | |
|--|-------------------------|---|---|
| 1. NAME OF DECEASED (Type or Print) CHARLENE ZIELINSKI | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> July 23, 1972 Hour 3:20 A. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour July 23, 1972 3:20 A. M. | |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 102 | | | |
| 6. SEX Female | 7. RACE White | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN Baltimore |
| 9. DATE OF BIRTH 6/2/54 | | 10. AGE (in years last birthday) 18 | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | E. STREET AND NUMBER potomac street 22 S. Potomac Street |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 14B. KIND OF BUSINESS OR INDUSTRY | 13. FATHER'S NAME George |
| 15. MOTHER'S MAIDEN NAME Mary Anna | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. | 18. INFORMANT MARG. ZIELINSKI |
| | | ADDRESS 22 S. POTOMAC ST. | |

| | | |
|--|--|---|
| 19. CAUSE OF DEATH E 966X | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE Stabwound of abdomen DUE TO, OR AS A CONSEQUENCE OF: |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (C) |

| | | | | |
|---|--|---|--|---|
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) Yes |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House | | 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? 2215 E. Lombard Street |
| 22D. TIME OF INJURY (APPROX.) 7-23-72 1 & 2:00 A.M. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Stabbed by unknown assailant |

| | | | | |
|---|--|--|--|---|
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL SIGNATURE Charles S. Springate | | M.D. | | DATE SIGNED July 25, 1972 |
| EXAMINER'S NAME (Type) Charles S. Springate, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |

| | | | |
|---|---|---|--|
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 7/28/72 | 24C. NAME of CEMETERY or CREMATORY Holly Hills Cem. | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | 25B. NAME OF REGISTRAR Audrey Whorton | 25C. FUNERAL DIRECTOR ADDRESS Bernard Dabrowski 2818 E. Balto. St | |

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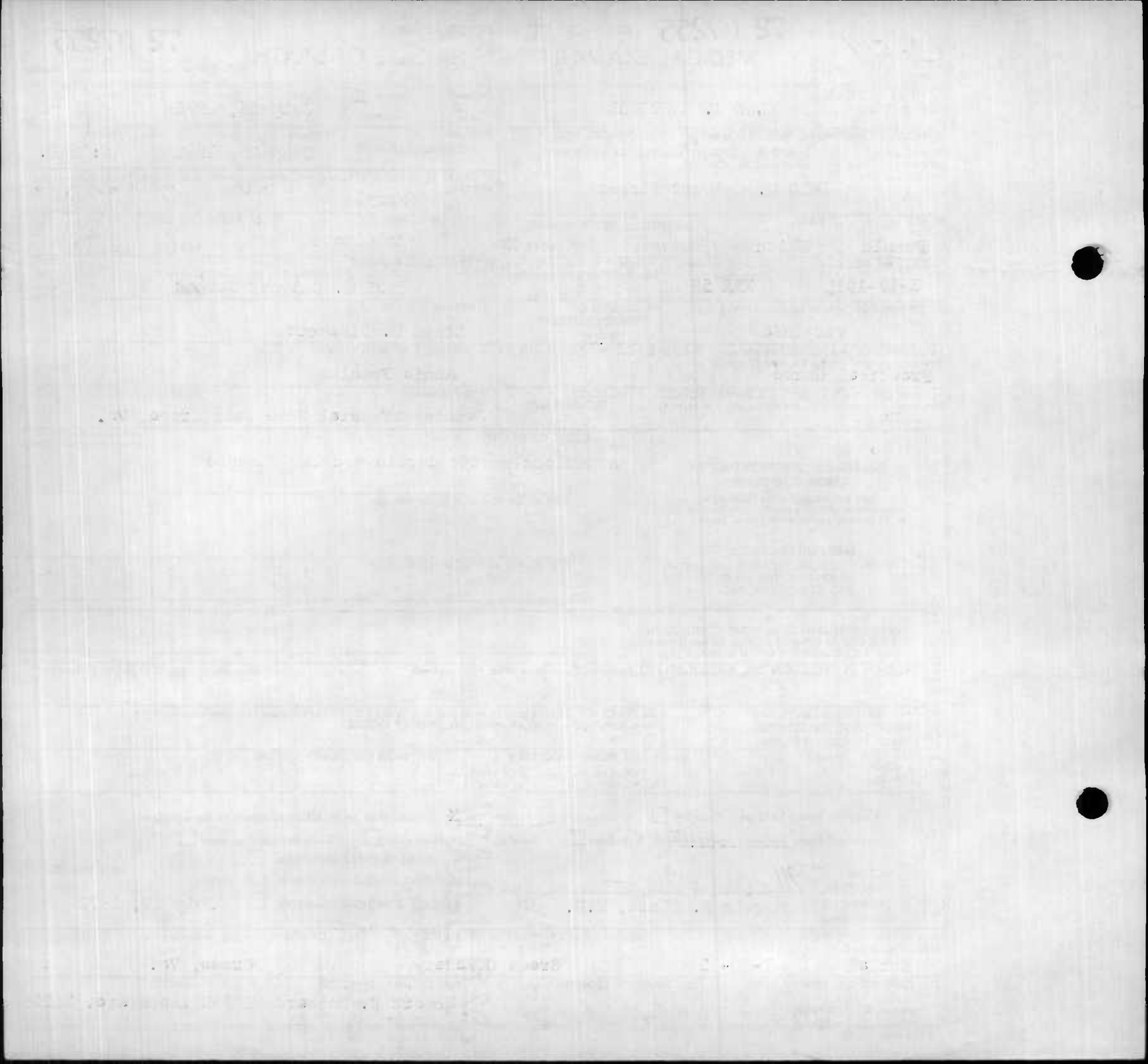
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07255

REG. NO.

BIRTH NO.

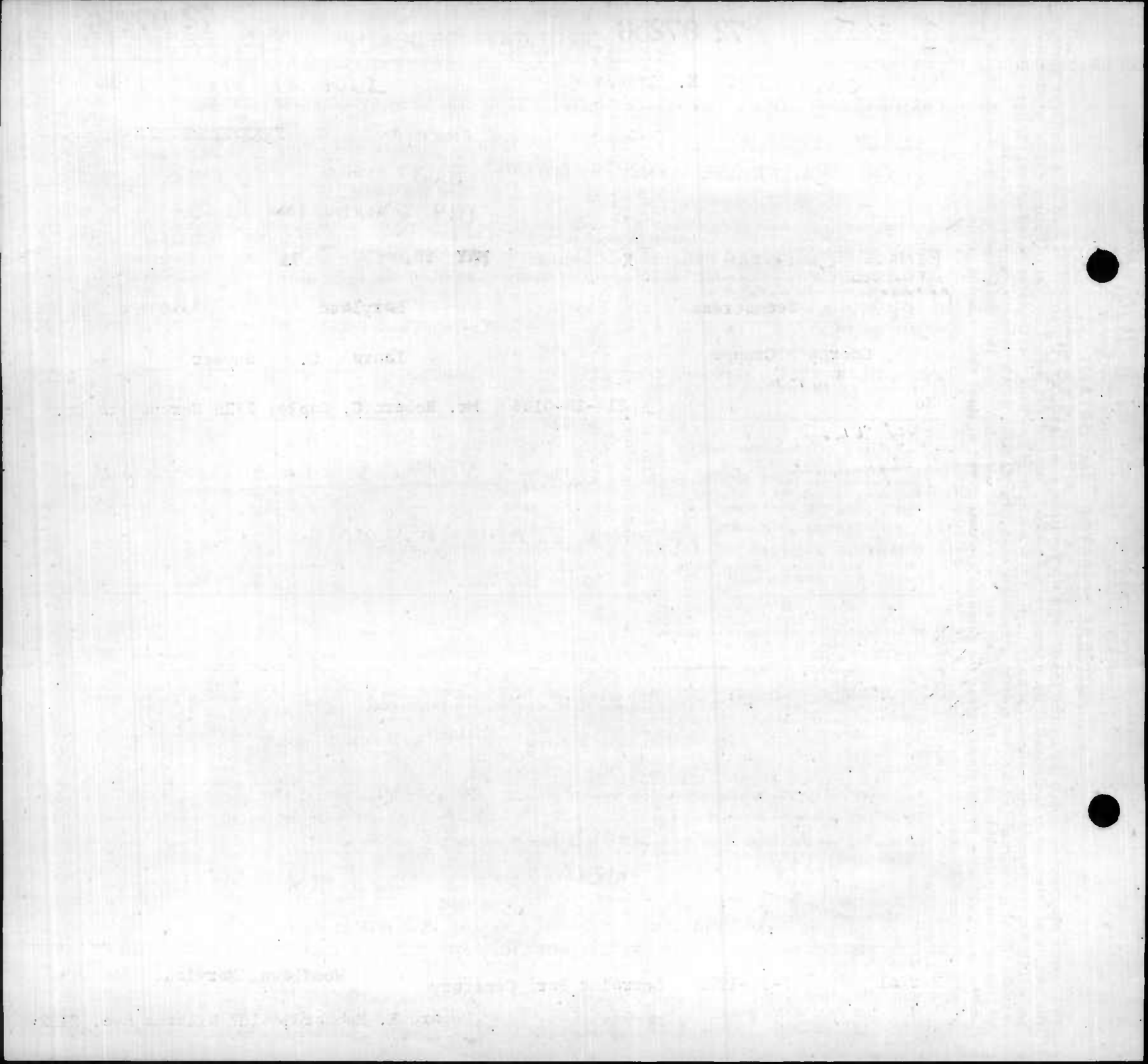
| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) LEE B. CAMPBELL | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour July 26, 1972 | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1632 N. Calvert Street | | 3. DATE PRONOUNCED DEAD Month Day Year Hour July 26, 1972 5:25 P. | |
| 6. SEX Female | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 3-17-1919 | | 10. AGE (In years lost birthday) 53 | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Lloyd D. Dinsmore | | 14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1205 | |
| 15. MOTHER'S MAIDEN NAME Annie Fowalks | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT ADDRESS Jenning sFuneral Home West Crewe, Va | |
| 19. 412.4 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) Yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 27, 1972 ACTUAL SIGNATURE Marvin S. Platt M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-30-72 | |
| 24C. NAME of CEMETERY or CREMATORY Crewe Cemetery | | 24D. LOCATION (City, town, or county) (State) Crewe, Va. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | 25B. NAME OF REGISTRAR Lidney | |
| 25C. FUNERAL DIRECTOR Howard H. Hubbard | | ADDRESS 4107 Wilkens Ave. 21229 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07256 | | 72 07256 | |
|--|--|--|--|--|--|---|--|
| BIRTH NO. 5-365 | | | | 72 07256 | | REG. NO. 72 07256 | |
| 1. NAME OF DECEASED (Type or Print) CATHERINE E. STRONG | | | | 2. DATE AND HOUR OF DEATH JULY 27 1972 9:30 P. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY XXXXXXXXXXXX 2102 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTIMORE GENERAL HOSPITAL 43 | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX FEMALE | | 6. RACE CAUCASIAN | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH MAY 18, 1897 | |
| 9. AGE (In years last birthday) 75 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Seamstress | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? UNITED STATES | |
| 13. FATHER'S NAME George Crophe | | | | 14. MOTHER'S MAIDEN NAME Laura C. Snyder | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 214-18-0136 | | 17. INFORMANT Mr. Robert C. Caple, 2723 Northshire Dr. | |
| 18. 436.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE CEREBRO-VASCULAR ACCIDENT 2 days DUE TO, OR AS A CONSEQUENCE OF: (B) ARTEROSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (X) (this hospital) attended the deceased from 7-25-72 19 to 7-27-1972, that (H) (we) last saw the deceased alive on 7-27-72 19 and that in (W) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE R. B. PATCH | | | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) R. B. PATCH | |
| 23D. ADDRESS 3001, S. HANOVER ST. | | | | 23E. PHYSICIAN'S NAME (Type) R. B. PATCH | | 23F. ADDRESS 3001, S. HANOVER ST. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-31-1972 | | 24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery | | 24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | 25B. NAME OF REGISTRAR Howard H. Hubbard | | 25C. FUNERAL DIRECTOR Howard H. Hubbard | | 25D. ADDRESS 4107 Wilkens Ave. 21229 | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07257

BIRTH NO.

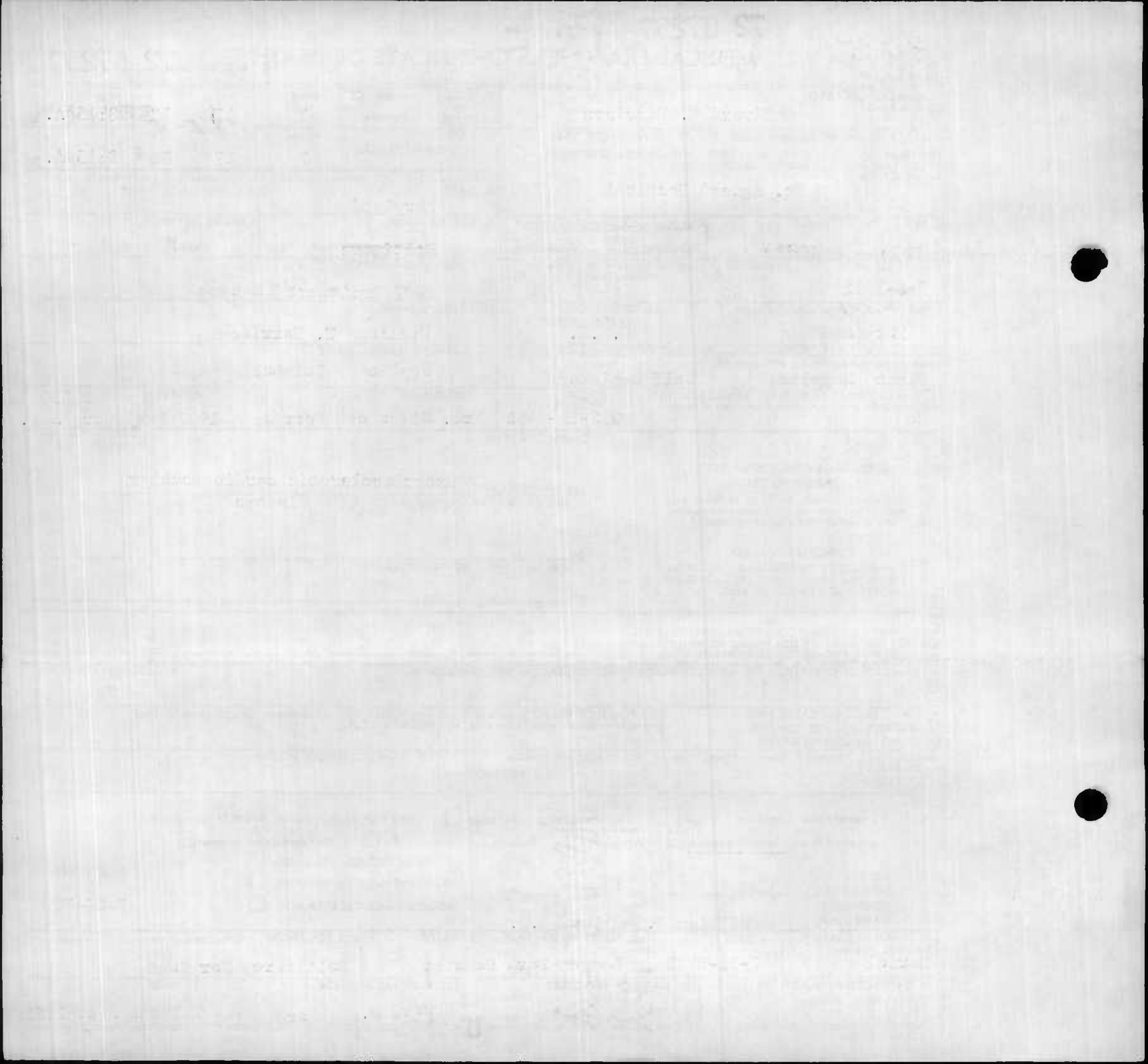
| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Edward T. Harrison | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 7 Day 27 Year 72 Hour 8:15 A. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Agnes' Hospital | | 3. DATE PRONOUNCED DEAD Month 7 Day 27 Year 72 Hour 8:15 A. M. | |
| 6. SEX Male | | 7. RACE White | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 5-8-1912 | | 10. AGE (In years lost birthday) 60 | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Floor Supplies | | 14B. KIND OF BUSINESS OR INDUSTRY Self Employed | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 212-10-8492 | |
| 18. INFORMANT Mrs. Elizabeth Harrison, 1907 Breitwert Ave. | | ADDRESS 21230 | |

| | | | |
|--|--|---|--|
| 19. CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | Arteriosclerotic cardiovascular disease | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |

| | | | | | |
|--|--|--|--|--|--|
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) No | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 22D. TIME OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |

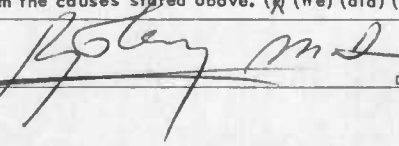
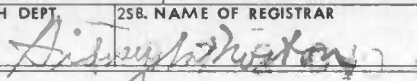
| | | | | | |
|---|--|--|--|--|--|
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <i>W P Mulloy</i> M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | |
| EXAMINER'S NAME (Type) William P. Mulloy, M.D. | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| | | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | |
| | | | DATE SIGNED 7-28-72 | | |

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-31-1972 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT AUG 1 1972 | | 25B. NAME OF REGISTRAR <i>Sidney B. Horton</i> | | 25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07258 | | 72 07258 | |
|--|----------------------|---|--|--|---------------------------------------|--|-------------------------------|
| BIRTH NO. 11-436 | | | | 72 07258 | | REG. NO. 72 07258 | |
| CERTIFICATE OF DEATH | | | | STATE OF MARYLAND-DHME | | | |
| 1. NAME OF DECEASED (Type or Print) XXXXXXXXXX MARIE FLORENCE WALTERS | | | | 2. DATE AND HOUR OF DEATH 07/27/72 12:45PM M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2582 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1001 DESOTO ROAD 21223 | | | |
| 5. SEX FEMALE | 6. RACE CAUCASIAN | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 03/25/00 | 9. AGE (In years last birthday) 72 | 10. Under 1 Yr. Months: Days: | 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME AUGUST SCHUSTER | | | | 14. MOTHER'S MAIDEN NAME KATHERINE X CROVO CATHERINE CROVO | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 215-44-0701 | | 17. INFORMANT ADDRESS ST AGNES HOSPITAL BALTO MD 21229 | |
| 18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ACUTE PULMONARY EDEMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. POSSIBLE ACUTE M.I. ASCVD severe | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 Hrs. | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that XIX (this hospital) attended the deceased from 07/27/72 19 to 07/27/72 19, that X (we) last saw the deceased alive on 07/27/72 19 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE  | | | | 23B. DATE SIGNED 07/27/72 | | 23C. PHYSICIAN'S NAME (Type) Howard H. Hubbard | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-31-1972 | | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | 25B. NAME OF REGISTRAR  | | 25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | |

12-1-1941

07/17/41

APPROXIMATE DATE OF BIRTH

12-1-1941

WATSON

BALTIMORE

ST AGNES HOSPITAL

1001 DETROIT ROAD

07/17/41

FEMALE CAUCASIAN

U.S.A.

MARYLAND

HOUSEWIFE

WATSON

WATSON

ST AGNES HOSPITAL BALTIMORE

NO

07/17/41

07/17/41

07/17/41

07/17/41

[Handwritten signature]

72 07259

STATE OF MARYLAND-DHMH
BALTIMORE CITY HEALTH DEPARTMENT

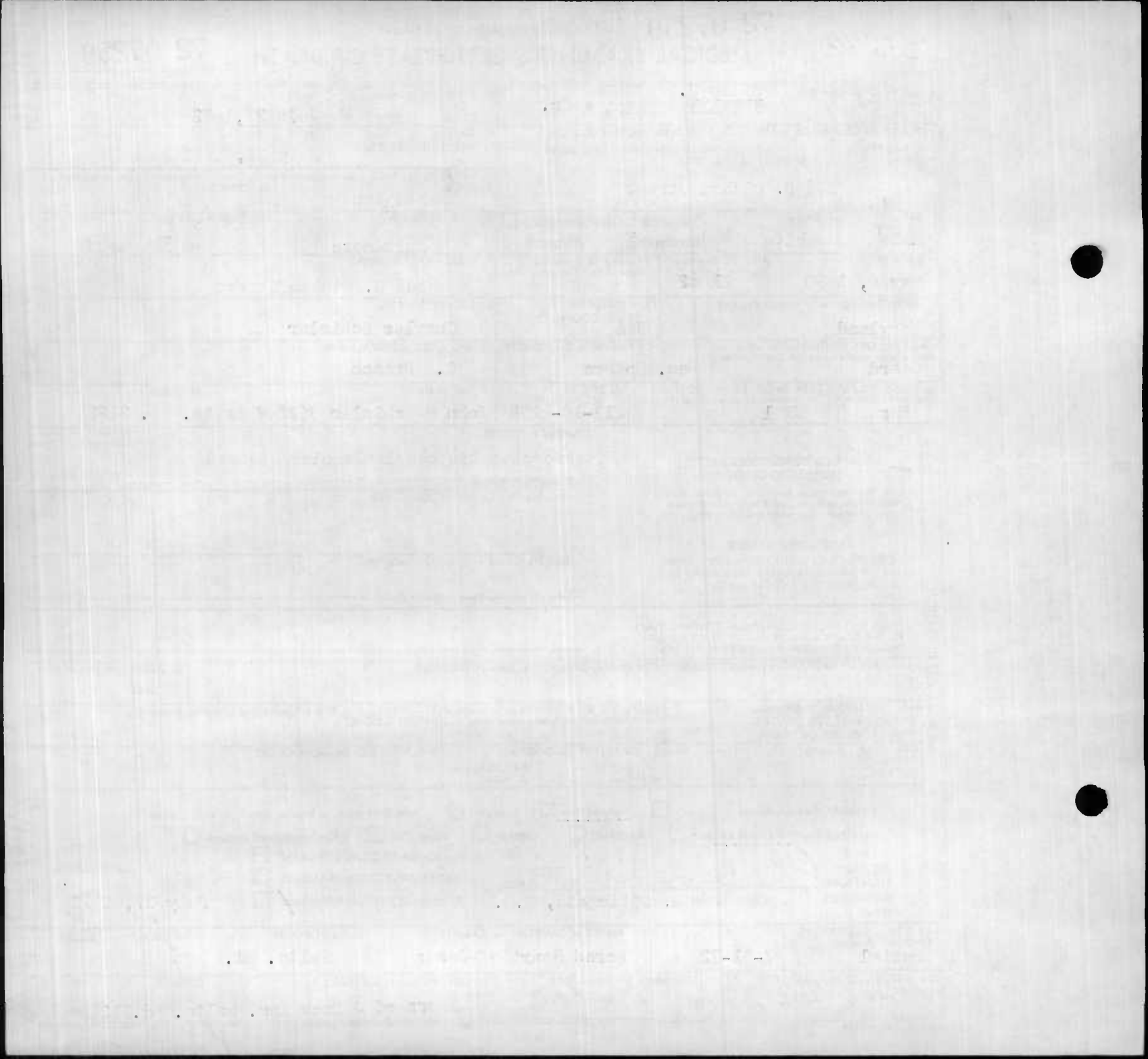
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07259

BIRTH NO.

REG. NO.

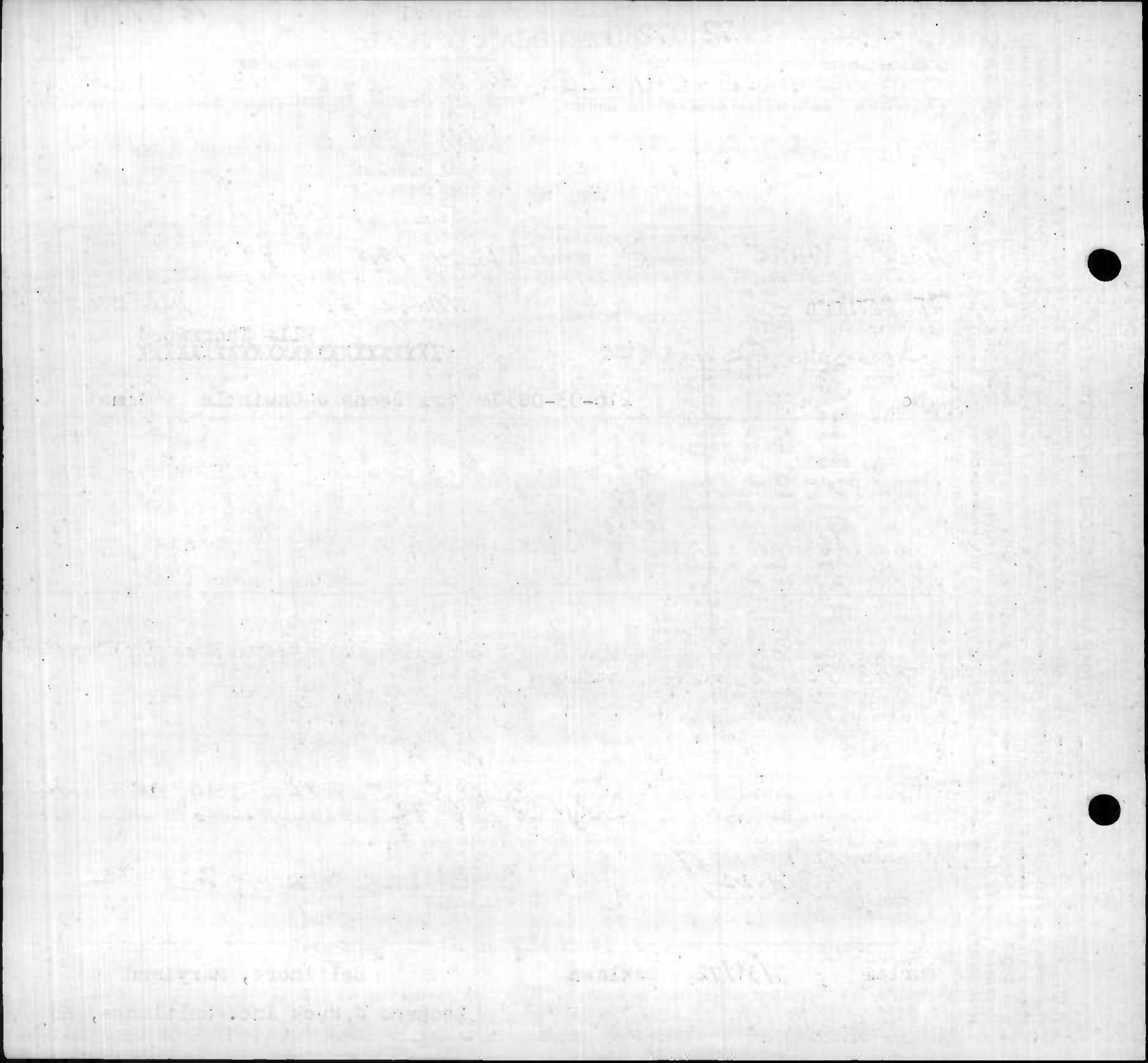
| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Philip P. SCHISLER Sr. | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> July 27, 1972 | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 346 S. Oldham Street | | 3. DATE PRONOUNCED DEAD Month Day Year Hour July 27, 1972 | |
| 6. SEX Male | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2607 | |
| 9. DATE OF BIRTH May 6, 1890 | | 10. AGE (In years last birthday) 82 | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard | | 15. MOTHER'S MAIDEN NAME C. Branch | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I | | 17. SOCIAL SECURITY NO. 213-10-4298 | |
| 18. INFORMANT John H Schisler | | ADDRESS 3526 E Balto. St. 21224 | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED July 27, 1972 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-31-72 | |
| 24C. NAME of CEMETERY or CREMATORY Sacred Heart of Jesus | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | 25B. NAME OF REGISTRAR Adrienne Horton | |
| 25C. FUNERAL DIRECTOR Leona and J Ruck Inc. | | ADDRESS Balto. Md. 21214 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

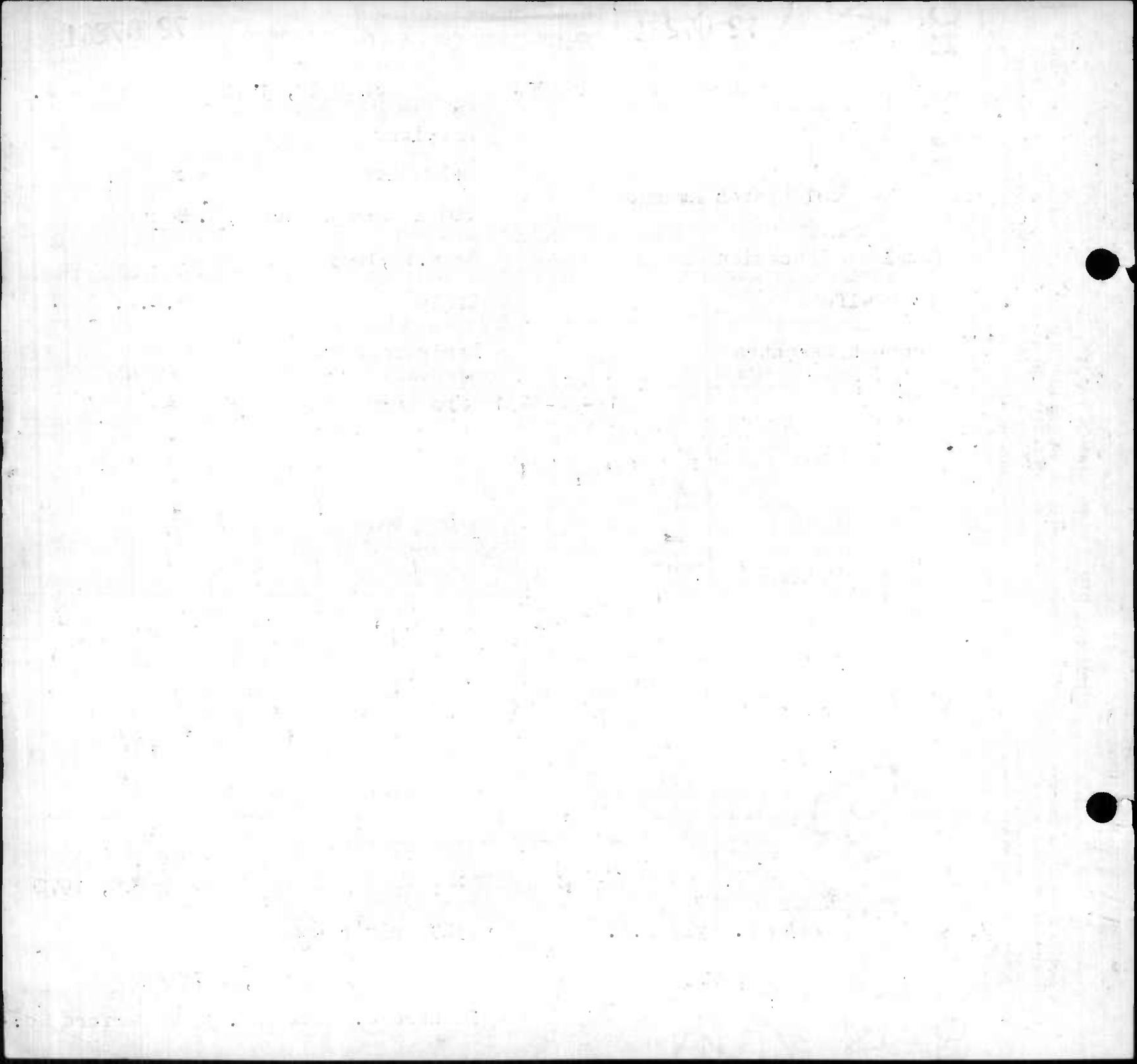
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07260 |
|--|-------------------------|--|---------------------------------------|--|
| 72 07260 CERTIFICATE OF DEATH | | | | REG. NO. |
| BIRTH NO. 0-252 | | STATE OF MARYLAND-DEATH | | |
| 1. NAME OF DECEASED (Type or Print) OSWINKLE, CHARLES W. | | 2. DATE AND HOUR OF DEATH July 28, 1972 12:40 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Union Memorial Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND 8. COUNTY 2641 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5502 ADLEIGH AVE. | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 04-14-1898 | 9. AGE (In years last birthday) 74 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PT. RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY? AMERICAN | | 13. FATHER'S NAME Joseph Oswinkle | | |
| 14. MOTHER'S MAIDEN NAME Ella Thornwood | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. 216-03-0830A | | 17. INFORMANT Mrs Leona J Oswinkle | | |
| 18. ADDRESS Same | | 19. CAUSE OF DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Pericardial Failure, Sepsis | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION 7-3-72 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Major G.I. bleeding | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from June 6, 1972 to July 28, 1972 , that (I) (we) last saw the deceased alive on July 28, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE Barbara J. | | 23B. DATE SIGNED 7-28-72 | | 23C. PHYSICIAN'S NAME (Type) Barbara J. |
| 23D. ADDRESS Barbara J. | | 23E. ADDRESS Barbara J. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/31/72 | | 24C. NAME OF CEMETERY or CREMATORY Oaklawn |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | |
| 25B. NAME OF REGISTRAR Barbara J. | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Baltimore, Md | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>72 07261</u> | |
|---|--|--|--|---|--|
| D-420 72 07261 | | | | STATE OF MARYLAND - BALTIMORE | |
| BIRTH NO. <u>72 07261</u> | | | | DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>ASSUNTA M DELUCA</u> | | | | 2. DATE AND HOUR OF DEATH <u>JULY 28, 1972</u> <u>10³⁰ - A.M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>801 Lenton Avenue</u> | | | | A. STATE <u>Maryland</u> B. COUNTY <u>2768</u> | |
| 5. SEX <u>Female</u> 6. RACE <u>Caucasian</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 8. DATE OF BIRTH <u>Sept. 13, 1885</u> 9. AGE (In years last birthday) <u>86</u> | | | | E. STREET AND NUMBER <u>801 Lenton Avenue Apt. B</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>Italy</u> | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Joseph DeFontes</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Marie Concetta</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, or unknown) (If yes, give war or dates of service) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. <u>219-32-0251</u> | |
| 17. INFORMANT <u>Mrs Mary Bass</u> | | | | ADDRESS <u>Same</u> | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma</u> | | | | <u>und.</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cancer of the stomach</u> | | | | <u>und.</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Chronic severe Cardiovascular Disease</u> | | | | <u>yes</u> | |
| 19A. DATE OF OPERATION <u>7-23-72</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>7-21-72</u> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5-23-61</u> 19 to <u>7-28-72</u> 19, that (I) (we) last saw the deceased alive on <u>7-21-72</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>John C. Hyle M.D.</u> | | | | 23B. DATE SIGNED <u>July 28, 1972</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>John C. Hyle M.D.</u> | | | | 23D. ADDRESS <u>7527 Belair Road</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>7/31/72</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u> | |
| 24D. LOCATION <u>Baltimore, Maryland</u> | | 24E. (City, town, or county) | | 24F. (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 1 1972</u> | | 25B. NAME OF REGISTRAR <u>Sidney H. Heston</u> | | 25C. FUNERAL DIRECTOR <u>Leonard J. Buck Inc.</u> | |
| 25D. ADDRESS <u>5305 Harford Rd.</u> | | 25E. (City, town, or county) | | 25F. (State) | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

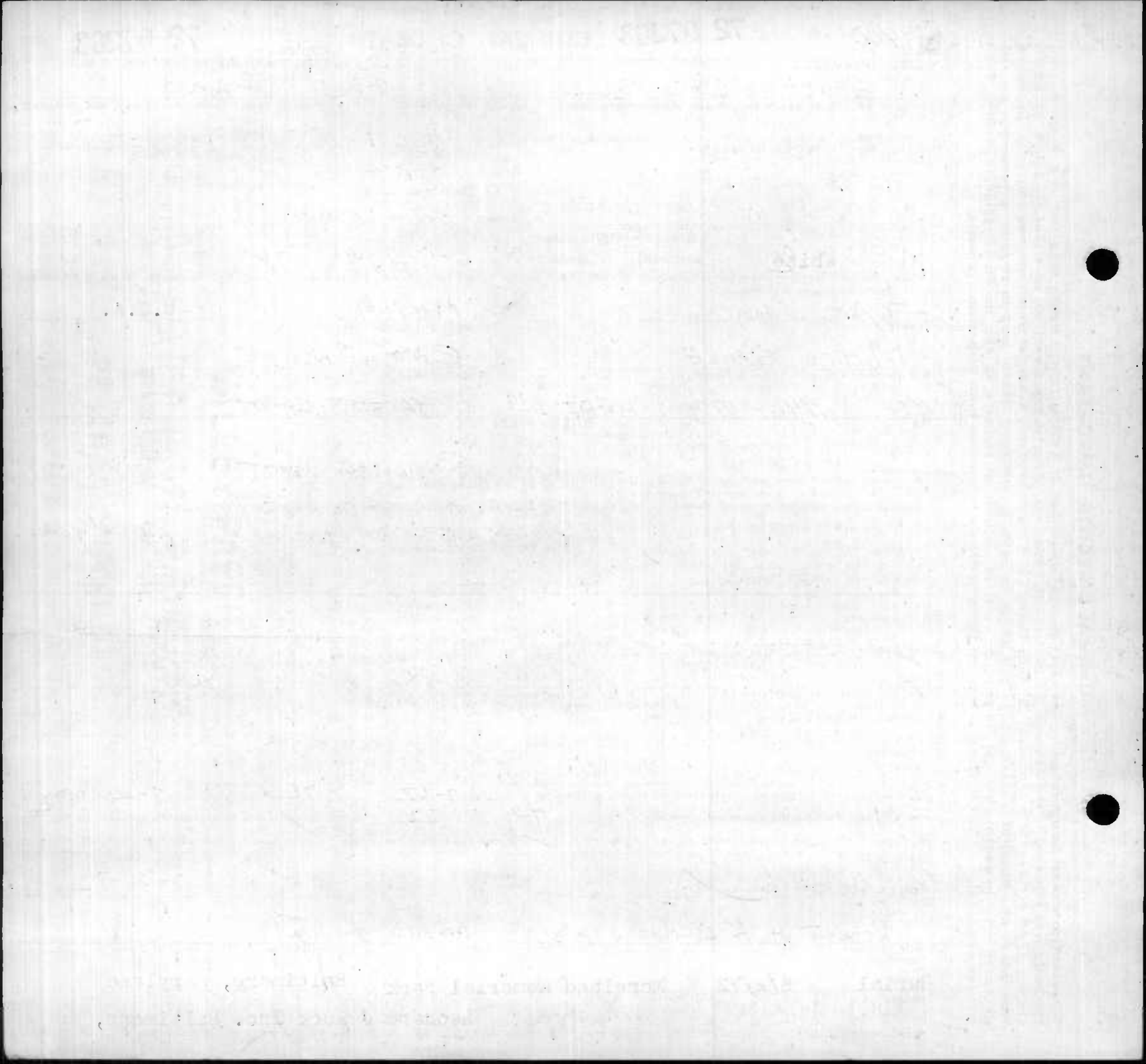
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07262 | | 72 07262 | |
|---|--|--|--|---|--|---|--|
| BIRTH NO. | | | | 72 07262 | | 72 07262 | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| HERBST, JAMES H. | | | | 7/30/72 8:05 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | | | |
| THE JOHNS HOPKINS HOSPITAL | | | | MARYLAND | | | |
| BALTIMORE, MD 21205 | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| BALTIMORE, MD 21205 | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX 6. RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | E. STREET AND NUMBER | | | |
| MALE WHITE | | | | 5811 HILLEN ROAD | | | |
| 8. DATE OF BIRTH 9. AGE (In years last birthday) | | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | |
| 07-29-91 81 | | | | Retired Eng. Balt. Gas & Elec. Co | | | |
| 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Penna. | | | | U.S.A. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| JAMES B. HERBST | | | | CATHERINE JONES | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| Yes WW I | | | | 220-14-7906 | | | |
| 17. INFORMANT | | | | ADDRESS | | | |
| Mrs Myrtle K Herbst | | | | Same | | | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) IMMEDIATE CAUSE | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | PNEUMONIA | | | |
| ANTECEDENT CAUSES | | | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) INTRACEREBRAL HEMATOMA | | | |
| (C) | | | | 10 days | | | |
| II | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 7/20/72 | | | | REMOVAL OF HEMATOMA | | | |
| 20A. AUTOPSY? (Yes or No) | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| NO | | | | (If in Baltimore City, give exact location) | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21C. WHERE DID INJURY OCCUR? | | | | 21D. TIME OF INJURY (APPROX.) | | | |
| (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED | | | |
| While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/20/72 19 to 7/30/72 19 | | | | that (I) (we) last saw the deceased alive on 7/30/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| JUAN LORA | | | | 7/30/72 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| JUAN LORA M.D. | | | | THE JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | | |
| Burial | | | | 8/2/72 | | | |
| 24C. NAME OF CEMETERY or CREMATORY | | | | 24D. LOCATION (City, town, or county) (State) | | | |
| Union Cemetery | | | | Glen Rock, Penna. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | | |
| AUG 1 1972 | | | | Leonard J. Buck Inc. Baltimore, Md | | | |
| 25C. FUNERAL DIRECTOR | | | | ADDRESS | | | |

EXHIBIT C

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

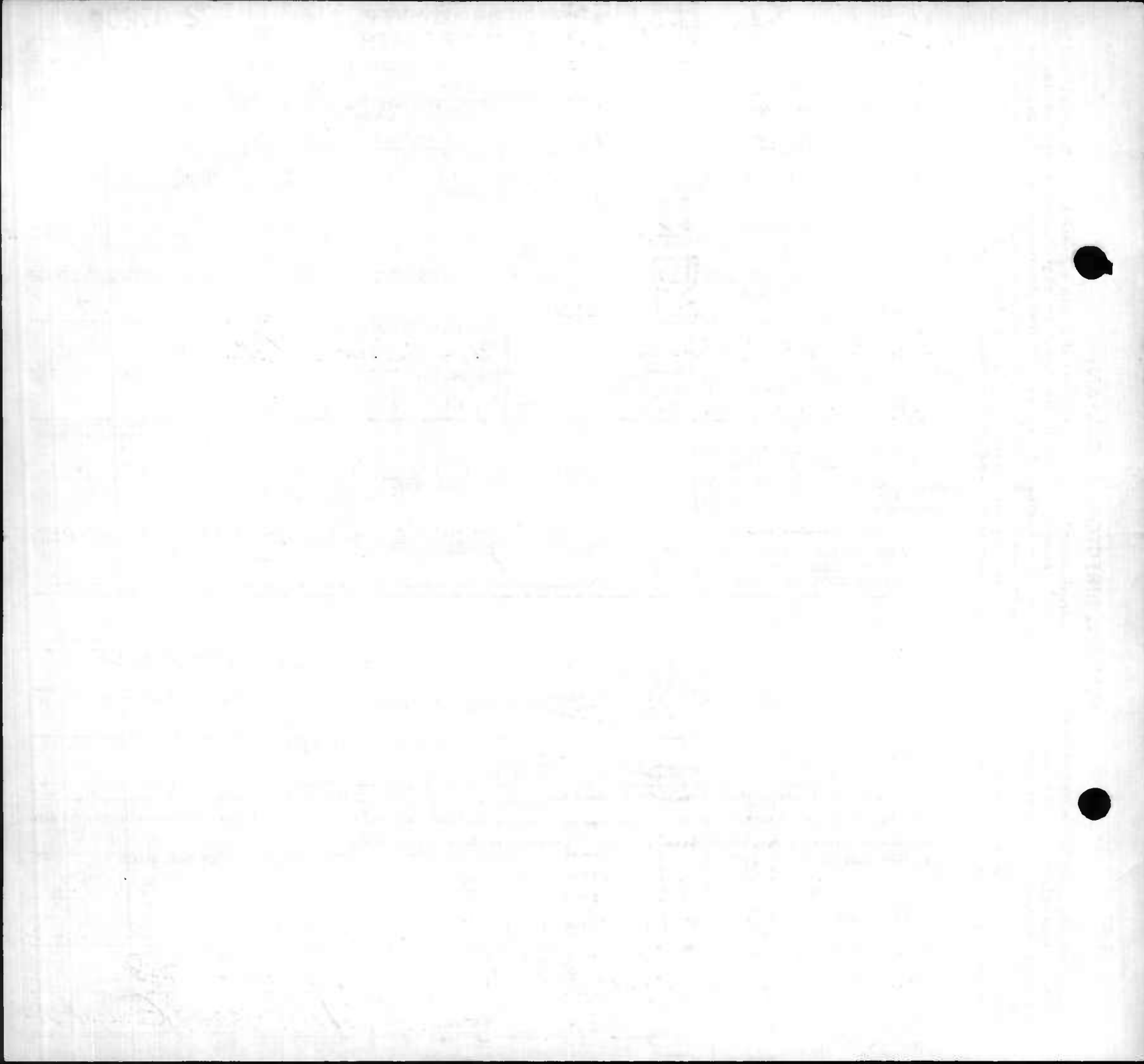
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>72 07263</u> |
|--|-------------------------|---|--------------------------------------|---|
| BIRTH NO. <u>G-400</u> | | 72 07263 | | STATE OF MARYLAND |
| 1. NAME OF DECEASED (Type or Print) <u>GAULE, STEPHEN EARL</u> | | 2. DATE AND HOUR OF DEATH <u>7-30-72 6:30 AM</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>BALTIMORE MARYLAND</u> 2778 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>US PHS Hospital</u> <u>273100 W YMAN PARK DRIVE</u> | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER <u>809 Evesham Avenue</u> | | | | |
| 5. SEX <u>M</u> | 6. RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-13-1894</u> | 9. AGE (In years last birthday) <u>78</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LTC/RET USNAVY</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | |
| 13. FATHER'S NAME <u>Michael GAULE</u> | | 14. MOTHER'S MAIDEN NAME <u>EMMA SNOW</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES 1940-1954</u> | | 16. SOCIAL SECURITY NO. <u>245-05-3129</u> | | 17. INFORMANT <u>PATIENT CHART</u> |
| 18. <u>491X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>ANTECEDENT CAUSES</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF: <u>CHRONIC BRONCHITIS AND Emphysema</u> (B) <u>(AIRWAY OBSTRUCTION by MUCUS)</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>several years</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>yes</u> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7-22</u> 19 <u>72</u> to <u>7-30</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>7-30</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <u>Robert H. Kirschner, M.D.</u> | | 23B. DATE SIGNED <u>7-30-72</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>ROBERT H. KIRSCHNER, M.D.</u> | | 23D. ADDRESS <u>US PHS Hospital</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>8/2/72</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Moreland Memorial Park</u> |
| 24D. LOCATION <u>Baltimore, Maryland</u> | | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT. <u>AUG 1 1972</u> | | 25B. NAME OF REGISTRAR <u>Sidney H. Houston</u> | | 25C. FUNERAL DIRECTOR <u>Leonard J Ruck Inc. Baltimore, Md</u> |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

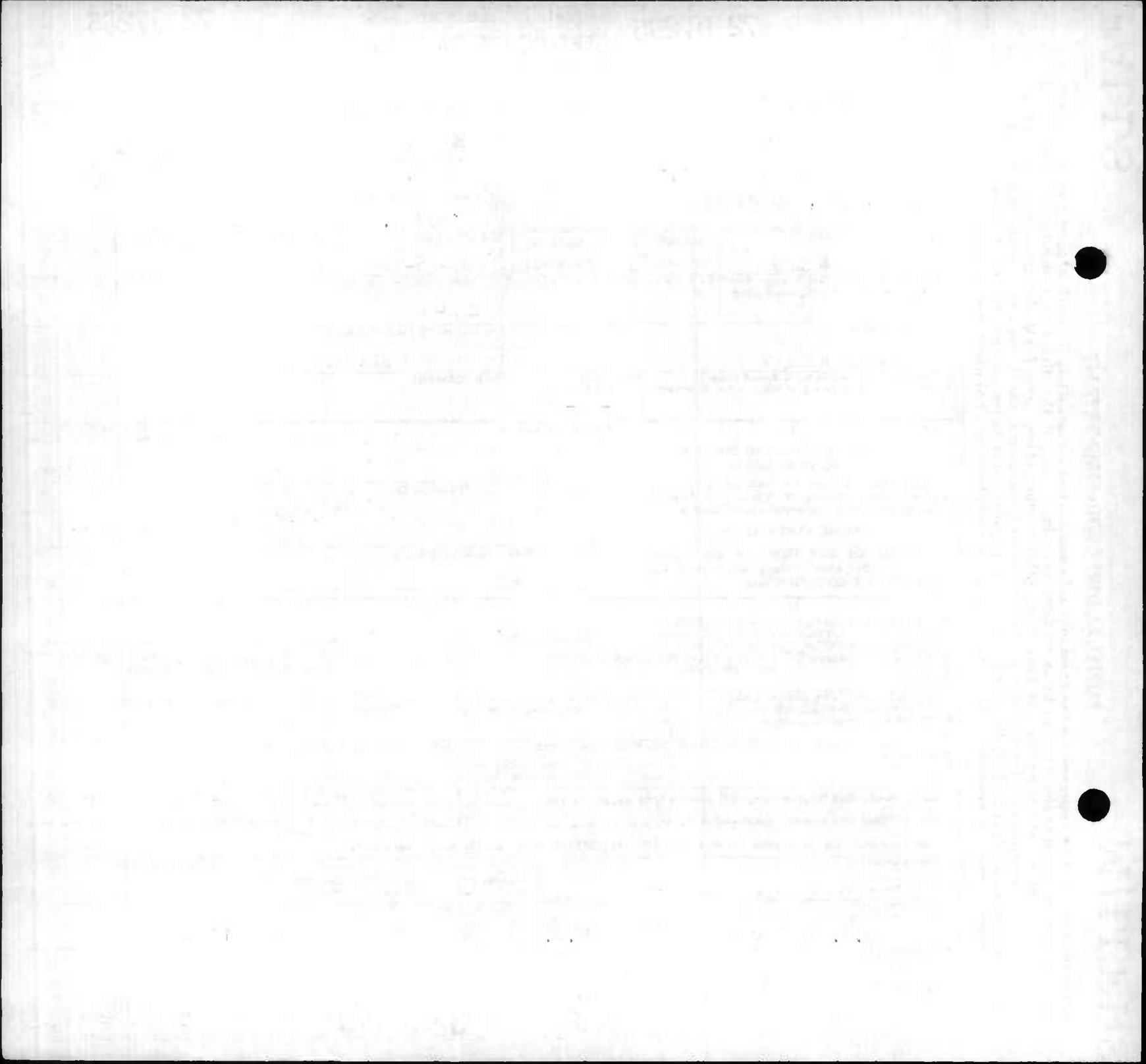
| | | | |
|--|---------------------|---|------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07264 | |
| BIRTH NO. M-245 | | 72 07264 | |
| 1. NAME OF DECEASED (Type or Print) STARLAND McCALLUM | | 2. DATE AND HOUR OF DEATH 7/30/72 3PM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1001 | |
| FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 | | E. STREET AND NUMBER 1205 N. Central Ave. | |
| 5. SEX M | 6. RACE B | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/14/15 |
| 9. AGE (In years last birthday) 57 | | 10. U.S. OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | |
| 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph Mc Callum | | 14. MOTHER'S MAIDEN NAME May Nellie Chalmers | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 10/14/41 - 10/28/45 | | 16. SOCIAL SECURITY NO. 213-07-6474 | |
| 17. INFORMANT patient and brother | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Arteriosclerotic Heart disease DUE TO, OR AS A CONSEQUENCE OF | |
| (C) | | (D) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION 7/30/72 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO | |
| 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO | |
| 21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 7/30/72 | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR 7/30/72 | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/30/72 to 7/30/72 that (I) (we) last saw the deceased alive on 7/30/72 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Stewart, M.D. | | 23B. DATE SIGNED 7/30/72 | |
| 23C. PHYSICIAN'S NAME (Type) D. W. STEWART, M.D. | | 23D. ADDRESS 2300 Garrison Blvd. (2126) | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/3/72 | |
| 24C. NAME of CEMETERY or CREMATORY Cedar Hill Cem. | | 24D. LOCATION (City, town, or county) (State) Q. D. County, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | 25B. NAME OF REGISTRAR Joseph A. Locks | |
| 25C. FUNERAL DIRECTOR Joseph A. Locks | | ADDRESS 1304 N. Central Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07265 | |
|---|-------------------------|---|--|--|---|
| L-200 72 07265 | | | | BIRTH NO. 3 26 96 | |
| CERIFICATE OF DEATH | | | | STATE OF MARYLAND-DEMH | |
| 1. NAME OF DECEASED (Type or Print) <u>IDA E. LEAK</u> | | | 2. DATE AND HOUR OF DEATH <u>7/29/72 12:45</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>833</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> <u>BALTIMORE, MD 21205</u> | | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER <u>1408 N. LAKEWOOD AVE</u> | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>NEGRO</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>03-26-96</u> | 9. AGE (In years last birthday) <u>76</u> | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>S.C.</u> | |
| 13. FATHER'S NAME <u>STEPHEN KELLEY</u> | | | 14. MOTHER'S MAIDEN NAME <u>HAGER JOHNSON</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>239-40-3666</u> | | 17. INFORMANT ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>410.01 + 250.9</u> (This does not mean the mode of dying, e.g., heart failure, aethenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH <u>Respiratory arrest ? Pulmonary embolism</u> <u>? transient arrhythmia</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Recent acute MI + intractable CHF</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>HASCVD</u> (C) <u>Diabetes mellitus, anemia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>100 min</u> <u>6 wks</u> <u>25 yrs</u> | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION <u>7/29</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7/22</u> 19 <u>72</u> to <u>7/29</u> 19 <u>72</u> and that (I) (we) last saw the deceased alive on <u>7/29</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>K.S. Alfredson</u> | | | 23B. DATE SIGNED | | |
| 23C. PHYSICIAN'S NAME (Type) <u>K.S. ALFREDSON</u> | | | 23D. ADDRESS <u>M.D. THE JOHNS HOPKINS HOSPITAL</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>8-1-72</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Baltimore Cemetery</u> | |
| 24D. LOCATION <u>Balt. Md.</u> | | 24E. DATE REC'D BY HEALTH DEPT. <u>AUG 1 1972</u> | | 24F. NAME OF REGISTRAR <u>Wm C MARCH</u> | |
| 24G. DATE REC'D BY HEALTH DEPT. <u>AUG 1 1972</u> | | 24H. NAME OF REGISTRAR <u>Wm C MARCH</u> | | 24I. FUNERAL DIRECTOR ADDRESS <u>928 E. North Ave</u> | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07266

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) JAMES A. GAINES | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2343 Harford Rd. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour M. 7 29 1972 12:15p | |
| 6. SEX male | | 7. RACE negro | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 3-10-06 | | 10. AGE (In years last birthday) 66 | |
| 11. BIRTHPLACE (State or foreign country) N.C. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME John C. Gaines | | 14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 805 | |
| 15. MOTHER'S MAIDEN NAME Ellen DeBerry | | E. STREET AND NUMBER 2343 Harford Rd. | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT Mrs. Lucille Francis | | ADDRESS | |
| 19. CAUSE OF DEATH Hypertensive & arteriosclerotic cardiovascular disease DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) no | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. M.D. EXAMINER'S NAME (Type) DATE SIGNED 7-30-72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-3-72 | |
| 24C. NAME OF CEMETERY or CREMATORY Balto. Cemetery | | 24D. LOCATION (City, town, or county) (State) Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | 25B. NAME OF REGISTRAR Andrew J. [Signature] | |
| 25C. FUNERAL DIRECTOR Wm C March | | ADDRESS 928 E North Ave. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07267

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
 STATE OF MARYLAND-DHMH

REG. NO.

72 07267

BIRTH NO.

1. NAME OF DECEASED
 (Type or Print)

BOLTON, FRANKLIN

2. DATE AND HOUR OF DEATH

7-30-72

7:55 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

37 Mercy

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
 A. STATE B. COUNTY

311 N. EAST STREET BALT. MD.

C. CITY OR TOWN

BALT. MD.

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

311 N. EAST STREET

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED ☐

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

6/12/1908

9. AGE (In years last birthday)

64

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

ROXBORO, N.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

WALTER BOLTON

14. MOTHER'S MAIDEN NAME

CARRIE SMITH

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

224-10-4982

17. INFORMANT

NORA BOLTON

ADDRESS

311 N. EAST STREET BALT. MD.

18. **410.0 I**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cardiac arrest

1h

(B)

DUE TO, OR AS A CONSEQUENCE OF:

acute Myocardial Infarction

1h

(C)

Hypertension

1

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from **7/30** 19 **72** to **7/30** 19 **72** that (I) (we) last saw the deceased alive on **7/30** 19 **72** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Tolen Ohe

MD DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

7/30/72

23C. PHYSICIAN'S NAME (Type)

Tohrv OHE

MD DEGREE

23D. ADDRESS

Mercy Hosp Baltimore MD

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

8/4/72

24C. NAME OF CEMETERY OR CREMATORY

MT. AUBURN CEMETARY

24D. LOCATION

(City, town, or county)

MT. WINNANS BALT. MD.

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 1 1972

25B. NAME OF REGISTRAR

Antony Houston

25C. FUNERAL DIRECTOR

1639 N. Broadway

ADDRESS

Sperry Funeral Home

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07268 | |
|--|------------------|--|----------------------------|--|---|
| BIRTH NO. 72 07268 | | CERTIFICATE OF DEATH | | STATE OF MARYLAND - DEMO | |
| 1. NAME OF DECEASED (Type or Print) William Cannon | | 2. DATE AND HOUR OF DEATH 7-24-72 1:25 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital, Inc. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 1007 E. PRESTON ST. 1001 C. CITY OR TOWN D. INSIDE CITY LIMITS? BALTIMORE, MD. 21205 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1007 E. PRESTON ST. | | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/1/31 | 9. AGE (In years last birthday) 41 | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONSTRUCTION WORKER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) SNOW HILL, N.C. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME JAMES CANNON | | 14. MOTHER'S MAIDEN NAME VICTORIA WILLIAMS 1007 E. PRESTON ST. BALT. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO. | | 16. SOCIAL SECURITY NO. 0443 | | 17. INFORMANT ADDRESS JAMES CANNON 1007 E. PRESTON ST. BALT. MD. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Alcoholism | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Exsanguination (Disseminated Intravascular Coagulation) (B) DUE TO, OR AS A CONSEQUENCE OF: DIC suggested (C) Heat stroke | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (X) (this hospital) attended the deceased from 7-23 19 72 to 7-24 19 72 that (X) (we) last saw the deceased alive on 7-24 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Claudius Klimt, M.D. | | 23B. DATE SIGNED 7-24-72 | | 23C. PHYSICIAN'S NAME (Type) Mercy Hospital, Inc. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 7/28/72 | | 24C. NAME OF CEMETERY OR CREMATORY MT AUBURN CEMETARY | |
| 24D. LOCATION (City, town, or county) (State) MT. WINNANS BALT. MD. | | 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | 25B. NAME OF REGISTRAR Sidney H. Heston | |
| 25C. FUNERAL DIRECTOR 1639 N. Broadway Funeral Home | | | | | |

(Continued from page 1)

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C-625

72 07269 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07269

| | | | | | |
|--|--|--|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) MARTON M. CHRUSNIAK | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 City Hospital | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 30 1972 4:25p M. | |
| 6. SEX male | | 7. RACE white | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH Aug. 12, 1932 | | 10. AGE (In years lost birthday) 39 | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Roman I. Chrusniak | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman Longshorman | |
| 15. MOTHER'S MAIDEN NAME Sophia Buccowski | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. 216-28-6186 | |
| 18. INFORMANT Margaret Chrusniak | | ADDRESS 2 N. Rose Street | | 19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease | |
| 20. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Marvin S. Platt, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 7-31-72 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-3-1972 | | 24C. NAME OF CEMETERY or CREMATORY St. Stanislaus | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | | |
| 25B. NAME OF REGISTRAR Andrew W. Boston | | 25C. FUNERAL DIRECTOR ADDRESS Milly & Zeiler Inc. 1901-07 Eastern Ave. | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-400 | | 72 07270 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07270 | |
|---|-----------|---|------------------|---|----------------------------|--|-----------------------------|
| BIRTH NO. | | | | REG. NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| John Bailey (JOHN F. BAILEY) | | | | 7/30/72 5:05 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | | | |
| Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | Maryland C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER | | | | 306 S. Lehigh Street 21224 | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (in years last birthday) | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| Male | Caucasian | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 3/1/98 | 74 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Retired | | Crown Cork & Seal | | Balto., Md. | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| George Bailey | | | | Louisa Strand | | | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No ----- | | 215-09-6746 | | BCH Records 4940 Eastern Ave. | | 21224 | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) IMMEDIATE CAUSE | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | cerebral metastases | | | |
| ANTECEDENT CAUSES | | | | (B) carcinoma of lung | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | | | (C) | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6-11 19 72 to 7-30 19 72 that (I) (we) lost saw the deceased alive on 7-30 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Herbert G. Markley M.D. | | | | 7/30/72 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Herbert G. Markley M.D. | | | | Baltimore City Hospitals Balto. Md. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 8-2-72 | | Oak Lawn Cemetery | | 7225 Eastern Blvd., Ba. Co., Md | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| AUG 1 1972 | | Sidney [Signature] | | Charles S. Zeiler | | 6224 Eastern Ave. Balto., 21224, Md. | |

Statement of [illegible]
[illegible]

Subscribed and sworn to before me this [illegible] day of [illegible] 19[illegible]
[illegible]

Notary Public
[illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 7-520 | | 72 07271 | | 72 07271 | |
|---|--|--|--|---|--|
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) | | CERTIFICATE OF DEATH | | STATE OF MARYLAND-DEM | |
| John W. Zang, JR. (ZANG) | | 2. DATE AND HOUR OF DEATH | | 7/29/72 3 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| 8 Maryland General Hospital | | 3814 Bank Street #21224 2608 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE | | B. COUNTY | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER | |
| MD. | | 9. AGE (in years last birthday) | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| MALE | | WHITE | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH | |
| Tavern owner | | 11. BIRTHPLACE (State or foreign country) | | 9-21-02 69 | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| JOHN W. ZANG, SR | | BERTHA FORSYTHE | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| NO | | 217-05-1912 | | BEATHA ZANG | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | Bronchogenic carcinoma with metastases | | | |
| ANTECEDENT CAUSES | | (A) IMMEDIATE CAUSE | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | (If in Baltimore City, give exact location) | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from | | July 29 1972 | | | |
| that (I) (we) last saw the deceased alive on | | June 29 1972 | | | |
| and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE | | | |
| Karen S. Fountain MD | | 23B. DATE SIGNED | | 7/29/72 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Karen S. Fountain MD | | 910 Belgian Avenue, Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| ENTOMBMENT | | 8-2-72 | | LORRAINE MEMORIAL PARK | |
| 25A. DATE REC'D BY HEALTH DEPT | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| AUG 1 1972 | | Sidney H. Hinton | | Charles S. Jester | |
| 25D. LOCATION (City, town, or county) (State) | | 25E. ADDRESS | | | |
| 5608 DOGWOOD RD. BALTO. CO., MD | | 901 S. CONKLING ST. BALTO., 21224, MD. | | | |

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104

THE STATE OF NEW YORK

IN SENATE

January 10, 1900

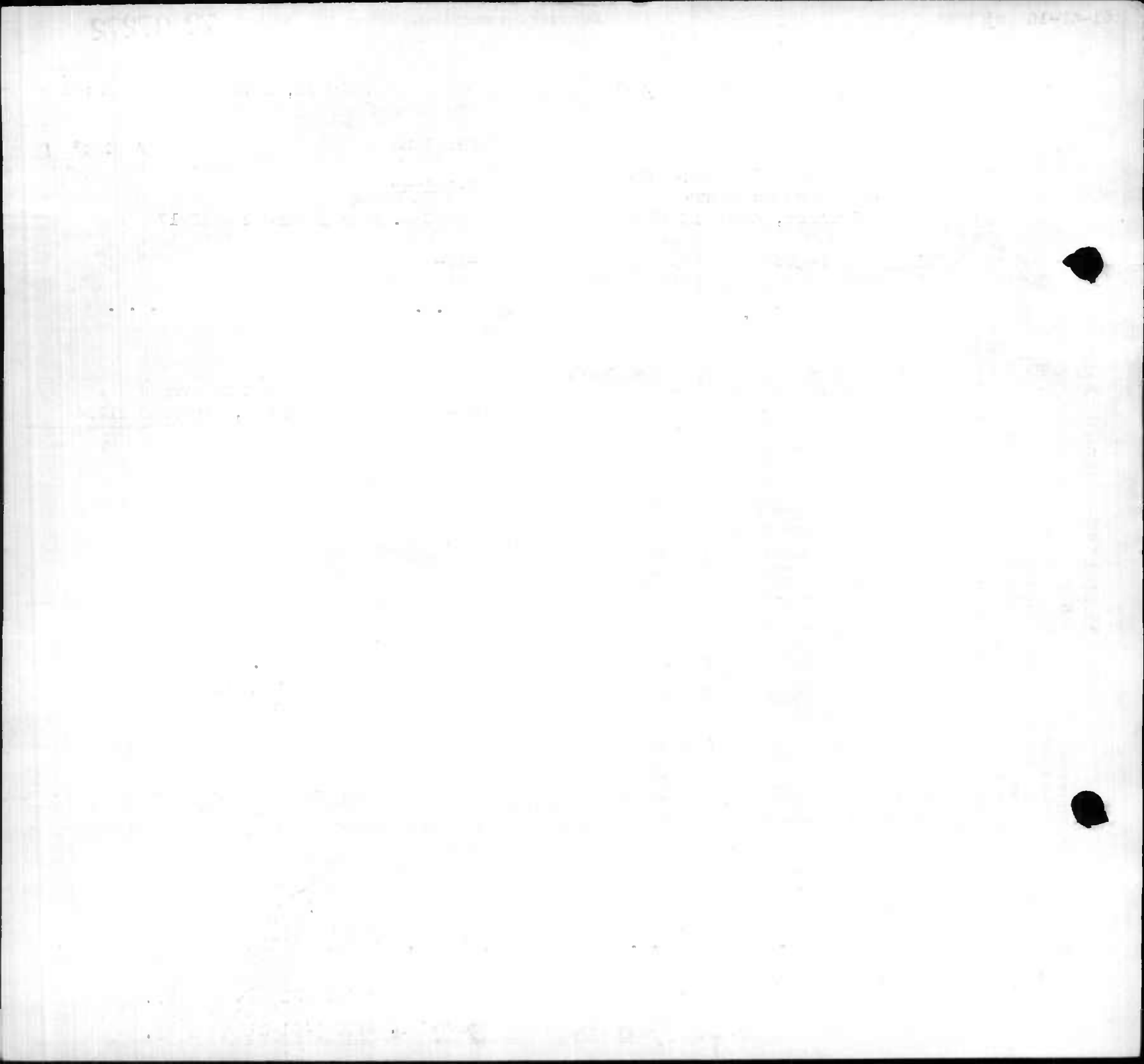
REPORT OF THE COMMISSIONER OF THE DEPARTMENT OF CORRECTIONS

ALBANY: PUBLISHED BY THE STATE OF NEW YORK, 1900.

CRIMINAL RECORDS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| L-200 72 07272 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07272 | |
|---|---------------|--|--------------------------|---|---|
| BIRTH NO. | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) Robert Luckey (Lucky) | | 2. DATE AND HOUR OF DEATH July 22, 1972 | | 12:42 p.m. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1800 W. Mosher Street 21227 | | 1604 | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-12-02 | 9. AGE (in years last birthday) 70 | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) S.C. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT BCH-Records 4940 Eastern Avenue Baltimore, Maryland 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4-27-01 + 25019 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE cardiac arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Unknown DUE TO, OR AS A CONSEQUENCE OF: (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | diabetes mellitus | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 15 19 72 to July 22 19 72 that (I) (we) last saw the deceased alive on July 22 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Hubert G. Markley M.D. | | 23B. DATE SIGNED 7/22/72 | | 23C. PHYSICIAN'S NAME (Type) Hubert G. Markley M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 7/25/72 | | 24C. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PARK | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | 25B. NAME OF REGISTRAR Sidney H. Hester | | 25C. FUNERAL DIRECTOR SAMUEL J. REDD 3401 GRANTLEY RD. | |



72 07273

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07273

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Anita Taska (Tasker)

2. DATE
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

7

24

72

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

3200 Auchentoroly Terr.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

P.M.

7

24

72

10:30

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

6. SEX

female

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

9-25-15

10. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3200 Auchentoroly Terr.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles Mooney

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Sarah Hall

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

219-30-9229

18. INFORMANT

Vernon Tasker

ADDRESS

3200 Auchentoroly Terr.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Electrocution

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES-PARTIAL

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIBUTING
CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

HOME

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

3200 Auchentoroly Terr.

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

7

24

72

?

m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject apparently electrocuted by
window fan.

23.

I certify that I held an Inquiry ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/25/72

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-29-72

24C. NAME of CEMETERY or CREMATORY

Woodlawn

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 1 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

Kenneth Law F H

ADDRESS

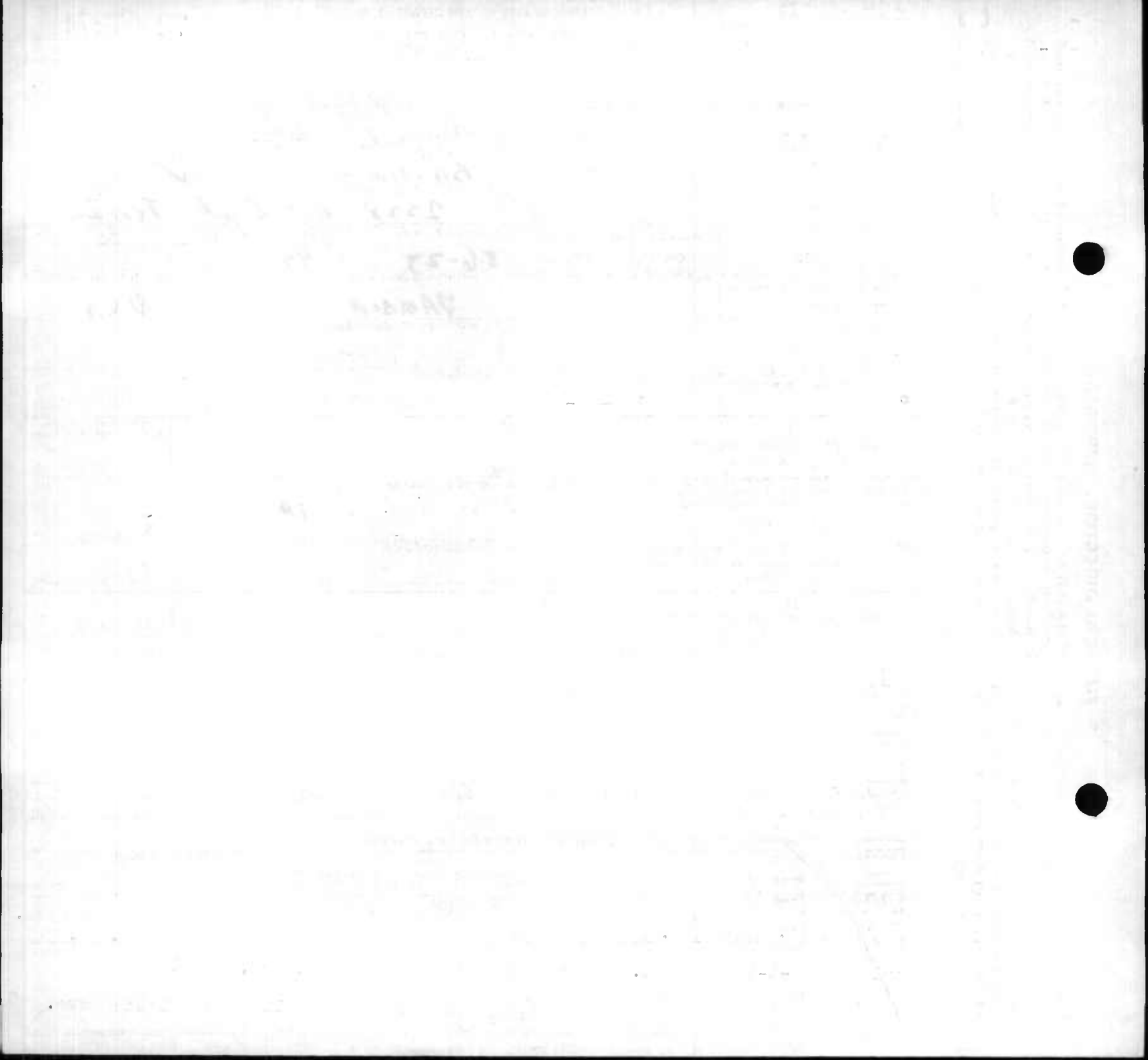
4611 Park Heights

8-28-1972 - Letter from the Office of the Chief Medical Examiner, Peter Lipkovic, M.D.
Assistant Medical Examiner. HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>72 07274</u> |
|--|-------------------------|---|-----------------------------------|---|
| BIRTH NO. <u>72 07274</u> | | CERTIFICATE OF DEATH STATE OF MARYLAND - DHEH | | |
| 1. NAME OF DECEASED (Type or Print) <u>ASTON HENRY</u> | | 2. DATE AND HOUR OF DEATH <u>7/27/72</u> <u>2:54</u> A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>BALTIMORE</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>BALTIMORE CITY Hospital 21224</u> | | C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| E. STREET AND NUMBER <u>2228 Mt Royal Terrace</u> | | F. ZIP CODE <u>21217</u> | | |
| 5. SEX <u>Male</u> | 6. RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-6-23</u> | 9. AGE (In years, last birthday) <u>49</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>JAMAICA</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Patrick</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Estella Martin</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>No</u> | | |
| 16. SOCIAL SECURITY NO. <u>104-28-5720</u> | | 17. INFORMANT <u>BCH: RECORDS</u> ADDRESS <u>4940 Eastern Avenue Baltimore, Maryland 21224</u> | | |
| 18. <u>593.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CHROIC RESPIRATORY DISEASE</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>50 years</u> | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE <u>HYPERKALEMIA</u> | | |
| | | (B) <u>HYPERKALEMIA</u> DUE TO, OR AS A CONSEQUENCE OF: <u>3 weeks</u> | | |
| | | (C) <u>Renal Failure</u> <u>5 yrs</u> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | <u>Pericardial effusion previous attack</u> <u>1 1/2 weeks</u> | | |
| 19A. DATE OF OPERATION <u>None</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | (If in Baltimore City, give exact location) | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>6/30</u> 19 <u>72</u> to <u>July 27</u> 19 <u>72</u> and that (I) (we) last saw the deceased alive on <u>July 27</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <u>Richard L. Sylvan M.D.</u> | | 23B. DATE SIGNED <u>July 27, 1972</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Richard L. Sylvan, M.D.</u> |
| 23D. ADDRESS <u>Baltimore City Hospitals 4940 Eastern Ave. 5762 E. Pratt Street Balto. Md. 21224</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | |
| 24B. DATE <u>8-1-72</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> |
| 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 1 1972</u> | | 25B. NAME OF REGISTRAR <u>Andrey In Boston</u> | | 25C. FUNERAL DIRECTOR <u>Kenneth Law</u> ADDRESS <u>4611 Park Heights Ave.</u> |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | 72 07275 | | REG. NO. 72 07275 | |
|--|---------------------|---|--|---|--|---|--|
| BIRTH NO. 72 07275 | | | | CERTIFICATE OF DEATH STATE OF MARYLAND - DEPT. | | | |
| 1. NAME OF DECEASED (Type or Print) LIZZIE M. BROWN | | | | 2. DATE AND HOUR OF DEATH JULY 28, 1972 2:30 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MD B. COUNTY BALT. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 34 BON SECOURS HOSPITAL | | | | C. CITY OR TOWN BALT. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | E. STREET AND NUMBER 753 W. FAYETTE ST. | | | |
| 5. SEX F | 6. RACE B | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2/11/22 | 9. AGE (in years last birthday) 50 | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 11. BIRTHPLACE (State or foreign country) W. Va. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME WALTER BROWN | | | | 14. MOTHER'S MAIDEN NAME ROSE COOPER | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 213-26-0999 | | 17. INFORMANT ADDRESS Rosa Lee Lewis 1028 W. Fayette Street | |
| 18. 427.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) abrupt fibrillation | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 days | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) CHF DUE TO, OR AS A CONSEQUENCE OF: | | weeks | |
| (C) - DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION 7/28/72 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/11/72 19 to 7/28/72 19 that (I) (we) last saw the deceased alive on 7/28/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Chaiman | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 7/28/72 | |
| 23C. PHYSICIAN'S NAME (Type) CHAIMAN | | | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-31-72 | | 24C. NAME OF CEMETERY OR CREMATORY Aubutus Memorial Park | | 24D. LOCATION (City, town, or county) (State) Arbutus, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | 25B. NAME OF REGISTRAR Sidney L. Brown | | 25C. FUNERAL DIRECTOR Kenneth Law | | ADDRESS 4611 Park Heights Ave. Arbutus, Md. | |

John H. ...

7th

ALDOUS ...

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|------------------|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07276 | |
| BIRTH NO. S-415 | | 72 07276 | |
| 1. NAME OF DECEASED (Type or Print) M. Gertrude Sullivan | | 2. DATE AND HOUR OF DEATH 7-30-72 3:00 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1211 St. Andrews Way | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTO C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1211 St. Andrews Way 21239 | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-17-1885 |
| 9. AGE (In years last birthday) 87 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd. Director E. J. Gallagher & Co. | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Timothy Francis Sullivan | |
| 14. MOTHER'S MAIDEN NAME Mary Girty | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. 213-12-8599 | | 17. INFORMANT Mr. Paul J. Plunkett 713 Fidelity Bldg. | |
| 18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Infarct of the heart DUE TO, OR AS A CONSEQUENCE OF: vascular disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | Pulmonary emphysema | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Mar 3 1954 to July 30 1972 , that (I) (we) last saw the deceased alive on 6-27 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Frederick J. Vollmer M.D. | | 23B. DATE SIGNED 7-31-72 | |
| 23C. PHYSICIAN'S NAME (Type) Frederick J. Vollmer, M. D. | | 23D. ADDRESS 6100 York Road | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-2-72 | |
| 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | 25B. NAME OF REGISTRAR Bridget M. Brown | |
| 25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. | | ADDRESS 4905 York Road Balto., Md. 21212 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07277 | | STATE OF MARYLAND-DEMU | |
|---|--|--|--|--|--|------------------------|--|
| L-344 72 07277 | | | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) | | | |
| Louise E. Littlehale | | | | 2. DATE AND HOUR OF DEATH | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | | | |
| 90 Long Green Nursing Home | | | | Maryland | | | |
| 5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | C. CITY OR TOWN D. INSIDE CITY LIMITS? | | | |
| | | | | Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | E. STREET AND NUMBER | | | |
| Homemaker | | | | 3939 Roland View Towers | | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | | 8. DATE OF BIRTH | | | |
| Own Home | | | | 6/12/1886 | | | |
| 11. BIRTHPLACE (State or foreign country) | | | | 9. AGE (In years last birthday) | | | |
| Phila. Pa. | | | | 86 | | | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | 13. FATHER'S NAME | | | |
| U.S.A. | | | | Charles F. Escher | | | |
| 14. MOTHER'S MAIDEN NAME | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| Louise Duncan | | | | No | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | |
| 215-22-1101 | | | | Charles Ford, 328 Paddington Rd. 21212 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | Cerebral vascular accident | | | |
| 19. ANTECEDENT CAUSES | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | Arteriosclerosis, generalized 5 yr. | | | |
| | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | H.C. VD | | | |
| | | | | (C) 10 yr. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION | | | | 20A. AUTOPSY? (Yes or No) | | | |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | | |
| | | | | 21E. INJURY OCCURRED | | | |
| | | | | While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (the hospital) attended the deceased from 10/21/72 to 7/31/72 | | | | 21F. HOW DID INJURY OCCUR? | | | |
| that (I) (the) last saw the deceased alive on 7/30/72 and that in (my) (the) opinion death occurred on the date and hour and from the causes stated above. (I) (the) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Norman R. Freeman, Jr. | | | | 7/31/72 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Norman R. Freeman, Jr. | | | | 11 W 29th St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | | |
| Burial | | | | 8/2/72 | | | |
| 24C. NAME OF CEMETERY OR CREMATORY | | | | 24D. LOCATION (City, town, or county) (State) | | | |
| St. Stephen's Church | | | | Earleville, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | | |
| AUG 1 1972 | | | | H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212 | | | |

3939 POLAND AVE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07278 | |
|--|--|--|--|--------------------------|---|
| BIRTH NO. 72 07278 | | | | STATE OF MARYLAND - DHMH | |
| 1. NAME OF DECEASED (Type or Print) <u>DUGAN, Anne S.</u> | | | 2. DATE AND HOUR OF DEATH <u>7-30-72</u> <u>5⁵⁰</u> <u>A</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>8-8-72</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2714</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>The Good Samaritan Hospital</u> <u>5601 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21239</u> | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH <u>12-19-11</u> 9. AGE (In years last birthday) <u>60</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | 13. FATHER'S NAME <u>John Sanford</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Gennie Carroll</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | |
| 16. SOCIAL SECURITY NO. <u>215 07 2604</u> | | | 17. INFORMANT <u>Daniel Dugan</u> ADDRESS <u>Same</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury at complication which caused death.) <u>adrenocarcinoma of breast with metastases</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | |
| 19A. DATE OF OPERATION <u>7/29</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Yes</u> | | |
| 20A. AUTOPSY? (Yes or No) <u>Yes</u> | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that <u>AT</u> (this hospital) attended the deceased from <u>7/29</u> 19 <u>72</u> to <u>7/30</u> 19 <u>72</u> , that <u>AT</u> (we) lost saw the deceased alive on <u>7/30</u> 19 <u>72</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>AT</u> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Richard J. Owellen M.D.</u> | | | 23B. DATE SIGNED <u>7/30/72</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Richard J. Owellen M.D.</u> | | | 23D. ADDRESS <u>5601 Loch Raven Boulevard 21239</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 24B. DATE <u>8-2-72</u> | | |
| 24C. NAME OF CEMETERY or CREMATORY <u>Greenmount</u> | | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 1 1972</u> | | | 25B. NAME OF REGISTRAR <u>Richard J. Owellen</u> | | |
| 25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u> | | | ADDRESS <u>4905 York Rd. Balto., Md. 21212</u> | | |

8-8-1972 - Correction form from Funeral Director-Henry W. Jenkins & Sons Co.

4905 York Road, Balto., Md. 21212

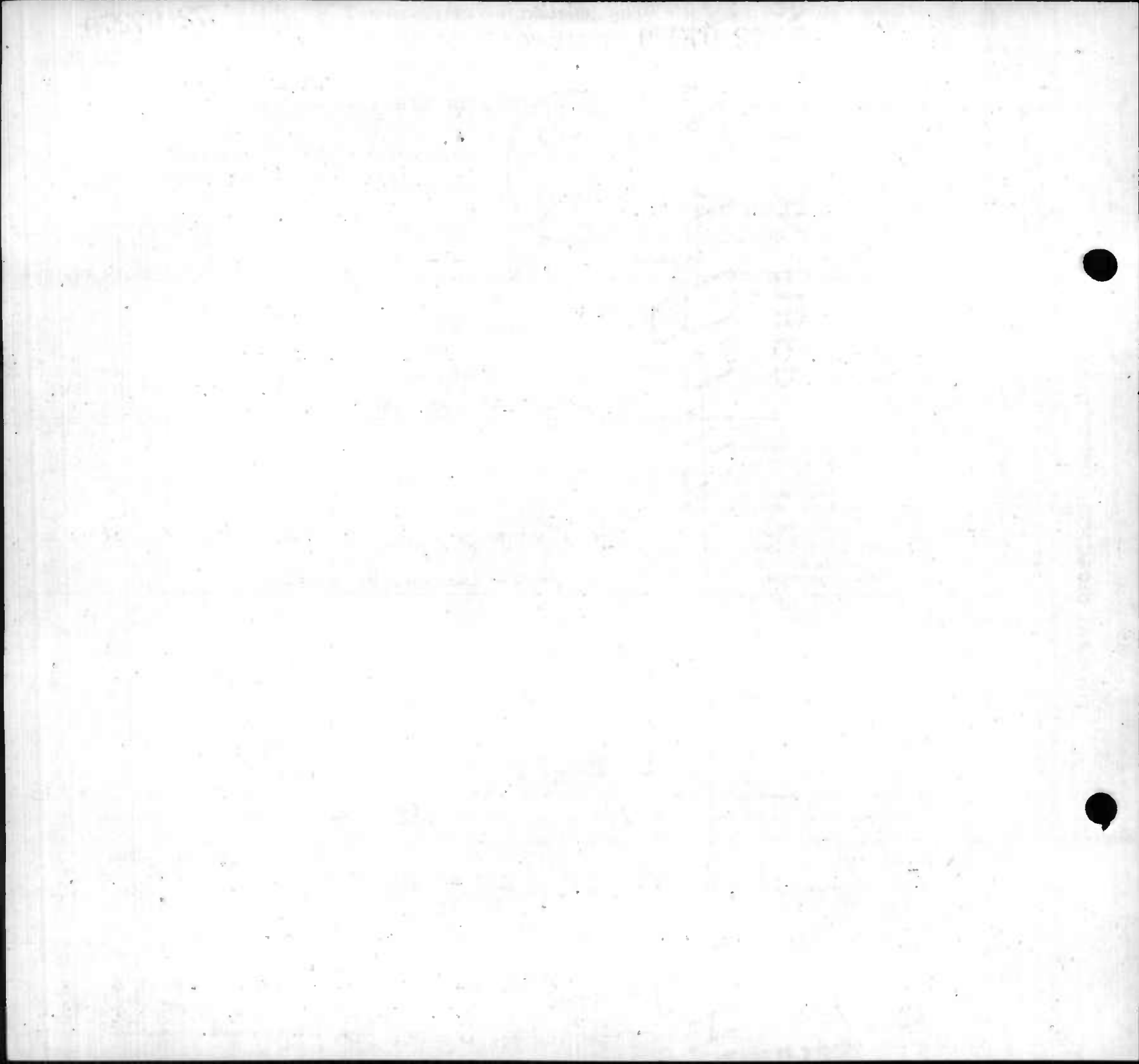
signed by John A. Slade, Pres.

HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

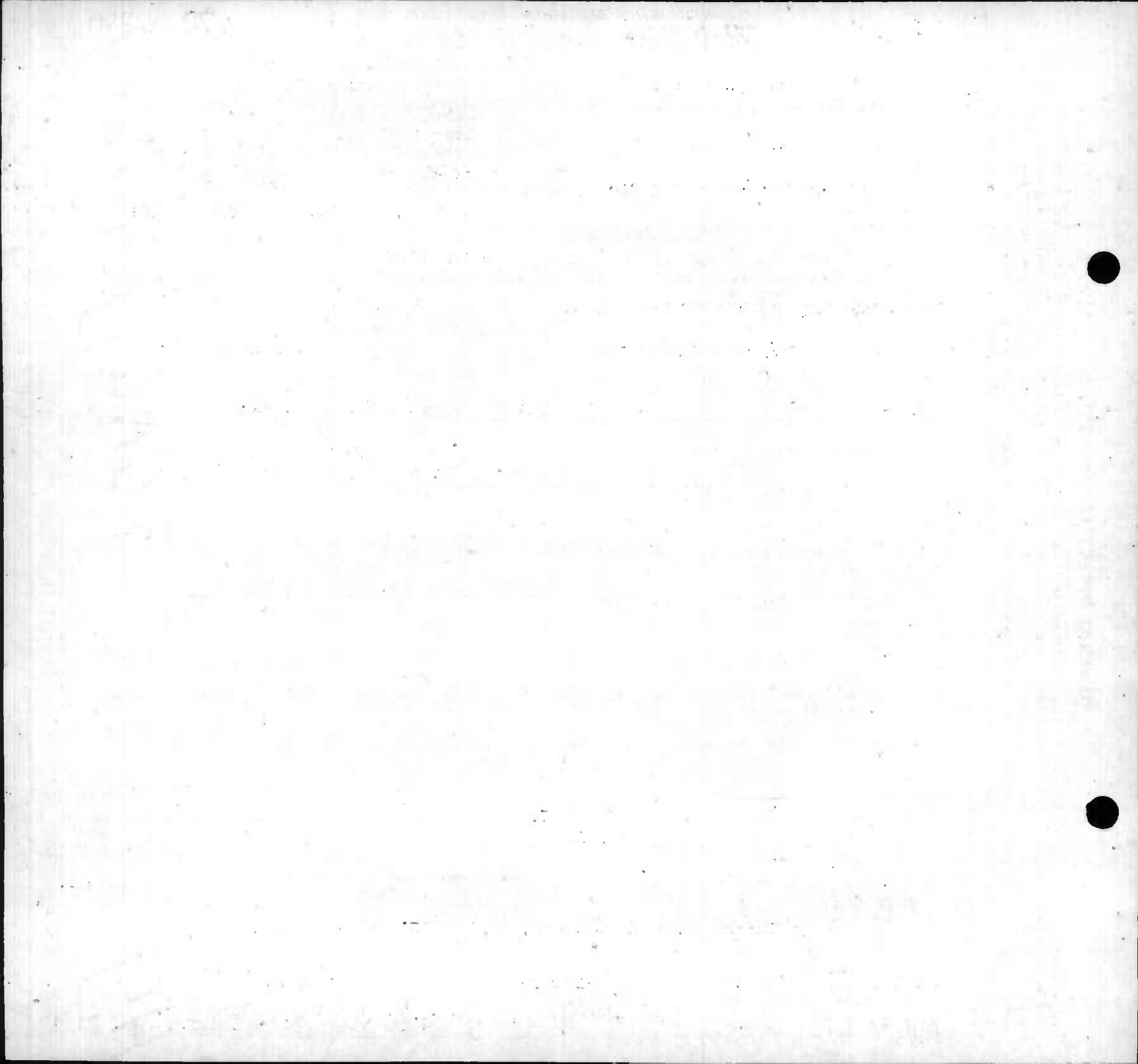
| | | | |
|---|--|--|--|
| <p>72 07279 CERTIFICATE OF DEATH</p> | | <p>REG. NO. 72 07279</p> | |
| <p>BIRTH NO. J-520</p> | | <p>STATE OF MARYLAND-DHMH</p> | |
| <p>1. NAME OF DECEASED (Type or Print) Mary Agnes Jones</p> | | <p>2. DATE AND HOUR OF DEATH 7-30-72 11:30 P.M.</p> | |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> | | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2758</p> | |
| <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2017 Swansea Rd. 21239</p> | | <p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> | |
| <p>5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p> | | <p>8. DATE OF BIRTH 1-9-1907 9. AGE (In years last birthday) 65 If Under 1 Yr. Months: Days: Hours: Min.</p> | |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker</p> | | <p>11. BIRTHPLACE (State or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? USA</p> | |
| <p>13. FATHER'S NAME Edward J. O'Malley</p> | | <p>14. MOTHER'S MAIDEN NAME Anna T. Brayden</p> | |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no</p> | | <p>16. SOCIAL SECURITY NO. 215-10-2363D 17. INFORMANT Mrs. Frank T. Hogan ADDRESS 6302 N. Charles St. 21212</p> | |
| <p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE M.I. DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis (C) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis</p> | | <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 1 year</p> | |
| <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p> | | | |
| <p>19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> | | <p>20A. AUTOPSY? (Yes or No) no 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p> | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | |
| <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | | <p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p> | |
| <p>21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/></p> | | <p>21F. HOW DID INJURY OCCUR?</p> | |
| <p>22. I certify that (I) (this hospital) attended the deceased from May 1955 to 7/30 1972, that (I) (we) last saw the deceased alive on 7/26 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | | | |
| <p>23A. SIGNATURE Conrad L. Richter M.D. 23B. DATE SIGNED 7/31/72</p> | | <p>23C. PHYSICIAN'S NAME (Type) Conrad Richter, M.D. 23D. ADDRESS 3128 Harford Rd.</p> | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 8-1-72 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery 24D. LOCATION (City, town, or county) Baltimore, Maryland (State) Md.</p> | | <p>25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 25B. NAME OF REGISTRAR H.W. Jenkins 25C. FUNERAL DIRECTOR H.W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212</p> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07280 | |
|--|-----------|---|--|--|---|
| 72 07280 | | | | STATE OF MARYLAND - DHE | |
| BIRTH NO. G-520 | | 1. NAME OF DECEASED (Type or Print) Hilary W. Gans | | 2. DATE AND HOUR OF DEATH July 31, 1972 6:00 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Long Green Nursing Home | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 100 W. Cold Spring Lane 21210 | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-21-1898 | 9. AGE (In years last birthday) 73 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd. Attorney Niles-Barton-Wilmer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Edgar Hilary Gans | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI | | | 16. SOCIAL SECURITY NO. 215-14-8750A | | 17. INFORMANT Mrs. Hilary W. Gans |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Interasclerotic - Corbi-Vascular disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 1972 to July 31 1972, that (I) (we) last saw the deceased alive on July 30 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE William G. Helfrich M.D. | | | | 23B. DATE SIGNED 1 Aug 42 | |
| 23C. PHYSICIAN'S NAME (Type) William G. Helfrich M.D. | | | | 23D. ADDRESS 5006 Roland Ave. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-3-72 | | 24C. NAME OF CEMETERY OR CREMATORY New Cathedral | |
| 24D. LOCATION Balto., Md. | | 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | | |
| 25B. NAME OF REGISTRAR Sidney H. Heston | | 25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 24905 York Road Balto., Md. 21212 | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07281

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) HENRY WILLIS | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hosp. (DOA) | | 3. DATE PRONOUNCED DEAD Month Day Year 7 29 1972 Hour 6:40p | |
| 6. SEX male | | 7. RACE negro | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 2-28-35 | | 10. AGE (In years last birthday) 37 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) CHARLOTTE, NORTH CAROLINA | | 12. CITIZEN OF U.S.A. | |
| 13. FATHER'S NAME DAVID WILLIS | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 15. MOTHER'S MAIDEN NAME GERTRUDE WILLIS | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | |
| 17. SOCIAL SECURITY NO. 239-50-2681 | | 18. INFORMANT MARILYN WILLIS | |
| 19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20. A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | 22. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 23. | |
| I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Ronald N. Kornblum, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 8-2-72 | |
| 24C. NAME of CEMETERY or CREMATORY MOUNT AUBURN CEMETERY | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 7 1972 | | 25B. NAME OF REGISTRAR Adrian J. Harrison | |
| 25C. FUNERAL DIRECTOR MORTON, & DYETT F. H. | | ADDRESS 1701 LAURENS ST. | |

1961

1961

X

27

2-2-61

DAVID WILTS

CHARLOTTE, NORTH CAROLINA, U.S.A.

REYNOLD WILTS

MARION WILTS 1903 BURNING ST.

27-2-61

27

27-2-61

27-2-61

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27-2-61

27-2-61

27-2-61

27-2-61

S-400

72 07282

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07282

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) JAMES SEWELL | | 2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 7 30 1972 11:12a. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 5108 Fredcrest Rd. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 30 1972 11:12a. | |
| 6. SEX male | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 7. RACE negro | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 12-25-93 | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 10. AGE (In years last birthday) 78 | | E. STREET AND NUMBER 5108 Fredcrest Rd. | |
| 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | | 12. CITIZEN OF U.S.A. | |
| 13. FATHER'S NAME JAMES SEWELL | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR | |
| 15. MOTHER'S MAIDEN NAME ANNE SEWELL | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT MRS. ZELMA CRAWLEY | |
| 19. 4 12 4 CAUSE OF DEATH Arteriosclerotic cardiovascular disease | | ADDRESS 5108 FREDCREST ROAD | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION 7-31-72 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) no | | 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 7 30 1972 | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| ACTUAL SIGNATURE Marvin S. Platt EXAMINER'S NAME (Type) Marvin S. Platt, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 8-2-72 | |
| 24C. NAME OF CEMETERY or CREMATORY MT. AUBURN CEMETERY | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 1 1972 | | 25B. NAME OF REGISTRAR Sidney J. Houston | |
| 25C. FUNERAL DIRECTOR MORTON & DYETT F. H. | | ADDRESS 1701 LAURENS ST. | |

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BIRTH NO. 72-03280

72 07283

CERTIFICATE OF DEATH

STATE OF MARYLAND - DHMH

1. NAME OF DECEASED
(Type or Print)

COATES, CHERYL LISA

2. DATE AND HOUR OF DEATH

7/30/72 12:50 AM

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)BALTIMORE CITY HOSPITALS
4940 Eastern Avenue4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

MARYLAND B. COUNTY

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1305 TENNANT WAY. 21224

5. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

2-18-72

9. AGE (In years
last birthday)

5 MONTHS

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

COATES, George

14. MOTHER'S MAIDEN NAME

RUTH DAVIS

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

None

17. INFORMANT Ruth M. Davis 1305 Tennant Way 21224
BCH- RECORDS 4940 Eastern Avenue

Baltimore, Maryland 21224

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE CARDIORESPIRATORY
DUE TO, OR AS A CONSEQUENCE OF: ARREST(B) ASPIRATION OF PROFOUSE UPPER
DUE TO, OR AS A CONSEQUENCE OF: RESPIRATORY TRUNK SECRETIONS

(C) AURI

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Severe Metabolic Acidosis

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (initially medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7-28-72 19 to 7-30 1972
that (I) (we) last saw the deceased alive on 7-30 1972 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Jose Salazar

DEGREE

Attending ☐ Phys.Med. ☐ DirectorStaff ☒ Phys.

23B. DATE SIGNED

7/30/72

23C. PHYSICIAN'S
NAME (Type)

JOSE D. SALAZAR

DEGREE

23D. ADDRESS

Baltimore City Hospitals

4940 EASTERN AVE. 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8-3-72

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 2 1972

25B. NAME OF REGISTRAR

Audrey Johnston

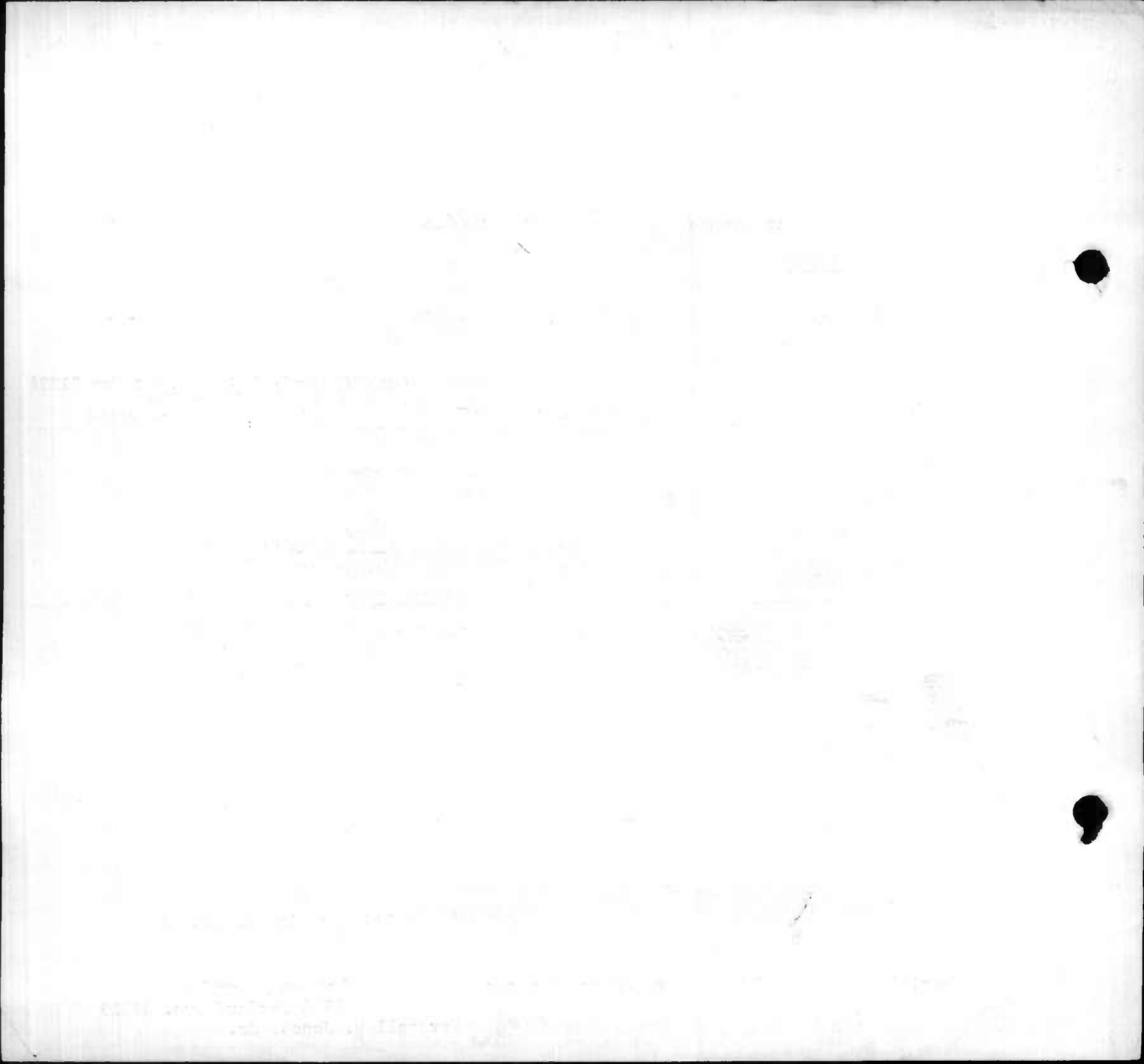
25C. FUNERAL DIRECTOR 1735 Harford Ave. 80013

Marshall W. Jones, Jr.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-320



F-602

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

72 07284

| | | | |
|---|------------------|--|--|
| BIRTH NO. 72-11495 72 07284 | | STATE OF MARYLAND - DHEM | |
| 1. NAME OF DECEASED (Type or Print) Michele Denise Franklin Baby Girl Douglas-Ruby | | 2. DATE AND HOUR OF DEATH 7/28/72 4:50 AM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224 | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2806 Kennedy Avenue 21218 | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/29/72 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10B. KIND OF BUSINESS OR INDUSTRY none | |
| 11. BIRTHPLACE (State or foreign country) Baltimore City Hospital Md. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13. FATHER'S NAME Larry Franklin | | 14. MOTHER'S MAIDEN NAME Ruby | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Larry Dan Franklin 2806 Kennedy Ave. 21218 Records: BCH: 4940 Eastern Ave. 21224 | | ADDRESS | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 7/26/72 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 hrs | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/27/72 19 to 7/28/72 19 that (I) (we) last saw the deceased alive on 7/28/72 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE D. JAMES MD. | | 23B. DATE SIGNED 7/28/72 | |
| 23C. PHYSICIAN'S NAME (Type) D. JAMES MD. | | 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave., Baltimore, Md. 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8-2-72 | 24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery | 24D. LOCATION City, town, or county) Baltimore, Maryland (State) |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR Sidney J. Jones, Jr. | |
| 25C. FUNERAL DIRECTOR 1735 Harford Ave. 21218 | | 25D. REGISTRAR 1735 Harford Ave. 21218 | |

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WASHINGTON, D. C. 20090

OFFICE OF THE ASSISTANT ATTORNEY GENERAL

WASHINGTON, D. C. 20090

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 67285

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

PHILLIP HINTON

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

38 University Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

7

28

1972

2:05 p

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md.

B. COUNTY

1505

6. SEX

male

7. RACE

hegro

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

1-30-38

10. AGE (In years
last birthday)

34

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2304 Ocala Ave.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Lewis Hinton

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Comm. Liason Worker

14B. KIND OF BUSINESS OR INDUSTRY

Balto. City Depart.

15. MOTHER'S MAIDEN NAME

Callie M. Hinton

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

yes

1 Nov 62
2 Nov 6217. SOCIAL
SECURITY NO.

219-32-6206

18. INFORMANT

Mrs. Carol Fax 4006 Chatham Rd. 21215

Mrs. Cordella W. Hinton 5612 Belleville Av. 07

19.

CAUSE OF DEATH

Gunshot wound of head

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRI-
BUTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

2304 Ocala Ave.

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

7-23-72

9:30 a

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot self.

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Marvin S. Platt, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-29-72

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8-1-72

24C. NAME of CEMETERY or CREMATORY

Arbutus Memorial Park

24D. LOCATION (City, town, or county)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 2 1972

25B. NAME OF REGISTRAR

Audrey H. Boston

25C. FUNERAL DIRECTOR

Marshall W. Jones, Jr.

1-10-72

Paula Hinton

11:30 AM

Baltimore, MD

Miss. Mary D. Hinton

Calista M. Hinton

Down. Hinton Hinton

of Hinton

1-10-72

11:30-12:00 PM

Mrs. Mary Hinton 4000 Chesapeake Rd. 21212
Mrs. Corbelle M. Hinton 3011 Baltimore St.

1-10-72

11:30-12:00

Arthur Memorial Park

Baltimore, Maryland

2735 Broadway Ave. 21212

Corbelle M. Hinton, Jr.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07286 | | REG. NO. 72 07286 | |
|---|---------------------|---|---|--|------------------------------|---|--|
| BIRTH NO. | | | | STATE OF MARYLAND-DEPT | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Conway Wendell Dashiell</u> | | | | 2. DATE AND HOUR OF DEATH <u>1 AUG 1972</u> M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2844</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hosp.</u> | | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | E. STREET AND NUMBER <u>1111 Wicklow Rd.</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>C</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 13-1919</u> | 9. AGE (In years last birthday) <u>53</u> | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>White Haven Md</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S</u> | | | | 13. FATHER'S NAME <u>George Dashiell</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Evelyn Conway</u> | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes 1941-1946</u> | | | |
| 16. SOCIAL SECURITY NO. <u>219-05-3305</u> | | | | 17. INFORMANT <u>Wife</u> | | | |
| 18. CAUSE OF DEATH <u>7/12/31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>7/12/31</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Coronary. atherosclerosis</u> 20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u> 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>H.C.V.A.</u> 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>NO</u> 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>NO</u> 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? <u>NO</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date _____ and hour _____ and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>J. Lee</u> | | | | 23B. DATE SIGNED <u>8-1-72</u> | | 23C. PHYSICIAN'S NAME (Type) <u>TURCOT JEDDY MD</u> | |
| 23D. ADDRESS <u>549 N. Fulton Ave</u> | | | | 24A. BURIAL CREMATION, REMOVAL <u>Burial</u> | | | |
| 24B. DATE <u>8-5-72</u> | | | | 24C. NAME OF CEMETERY or CREMATORY <u>White Haven</u> | | | |
| 24D. LOCATION (City, town, or county) (State) <u>White Haven Md</u> | | | | 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 2 1972</u> | | | |
| 25B. NAME OF REGISTRAR <u>Andrew W. ...</u> | | | | 25C. FUNERAL DIRECTOR <u>3700 Edmondson Ave.</u> | | | |
| 25D. ADDRESS <u>3700 Edmondson Ave.</u> | | | | | | | |

WALLACE POND

WALLACE POND

USA

FUNERAL DIRECTOR: IMPORTANT

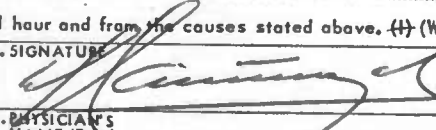
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

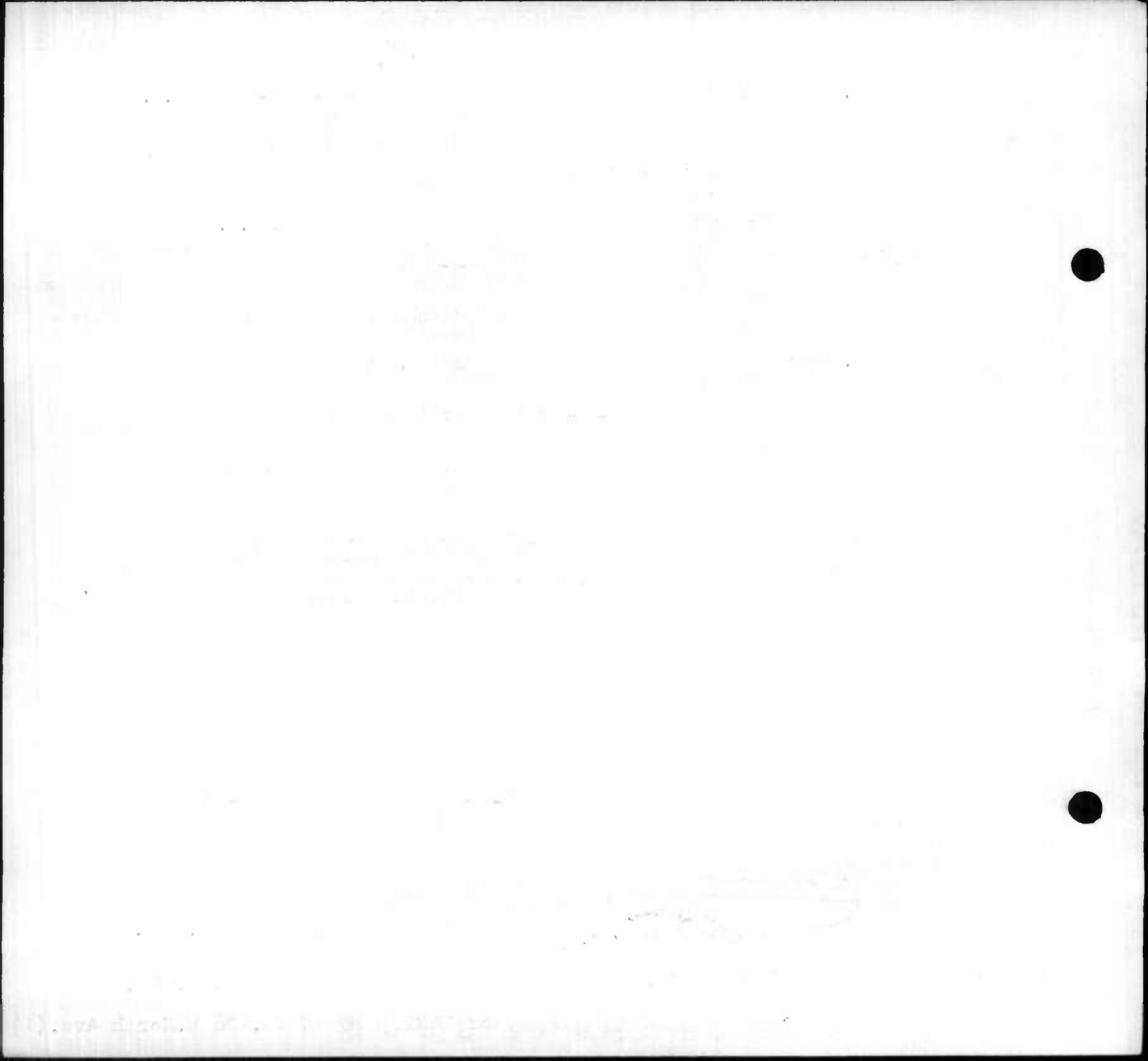
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07287 | | 72 07287 | |
|---|--|---|--|---|--|---|--|
| BIRTH NO. | | | | 72 07287 | | 72 07287 | |
| 1. NAME OF DECEASED (Type or Print) <u>Cameron John Mc DANIEL</u> | | | | 2. DATE AND HOUR OF DEATH <u>July 27, 1972 240A</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1206</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>48 MARYLAND GENERAL HOSPITAL</u> | | | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <u>Male</u> | | 6. RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>11-14-08</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday) <u>63</u> | | 11. BIRTHPLACE (State or foreign country) <u>Dillon, S. C.</u> | |
| 13. FATHER'S NAME <u>William D. McDaniel</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sarah Roberta Bryant</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u> | | | | 16. SOCIAL SECURITY NO. <u>249-01-9725</u> | | 17. INFORMANT wife: Inez McDaniel ADDRESS <u>2106 St. Paul Street</u> | |
| 18. <u>485X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>BRONCHIAL PNEUMONIA</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>ARTERIOSCLEROSIS PERIPHERAL VASCULAR DISEASE & GANGRENE</u> | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>July 23, 1972</u> to <u>July 27, 1972</u> that (I) (we) last saw the deceased alive on <u>July 26, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Newton W. Rogers MD</u> | | | | 23B. DATE SIGNED <u>7/27/72</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>NEWTON W. ROGERS</u> | | | | 23D. ADDRESS <u>MARYLAND GENERAL Hosp</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>8/1/72</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Garden of Faith</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 2 1972</u> | | | | 25B. NAME OF REGISTRAR <u>Stewart & Mowen</u> | | | |
| | | | | 25C. FUNERAL DIRECTOR ADDRESS <u>STEWART & MOWEN CO. 108 W. North Ave (1)</u> | | | |

8 BORDO BORDO

ADVERTISING & MARKETING
ADVERTISING & MARKETING

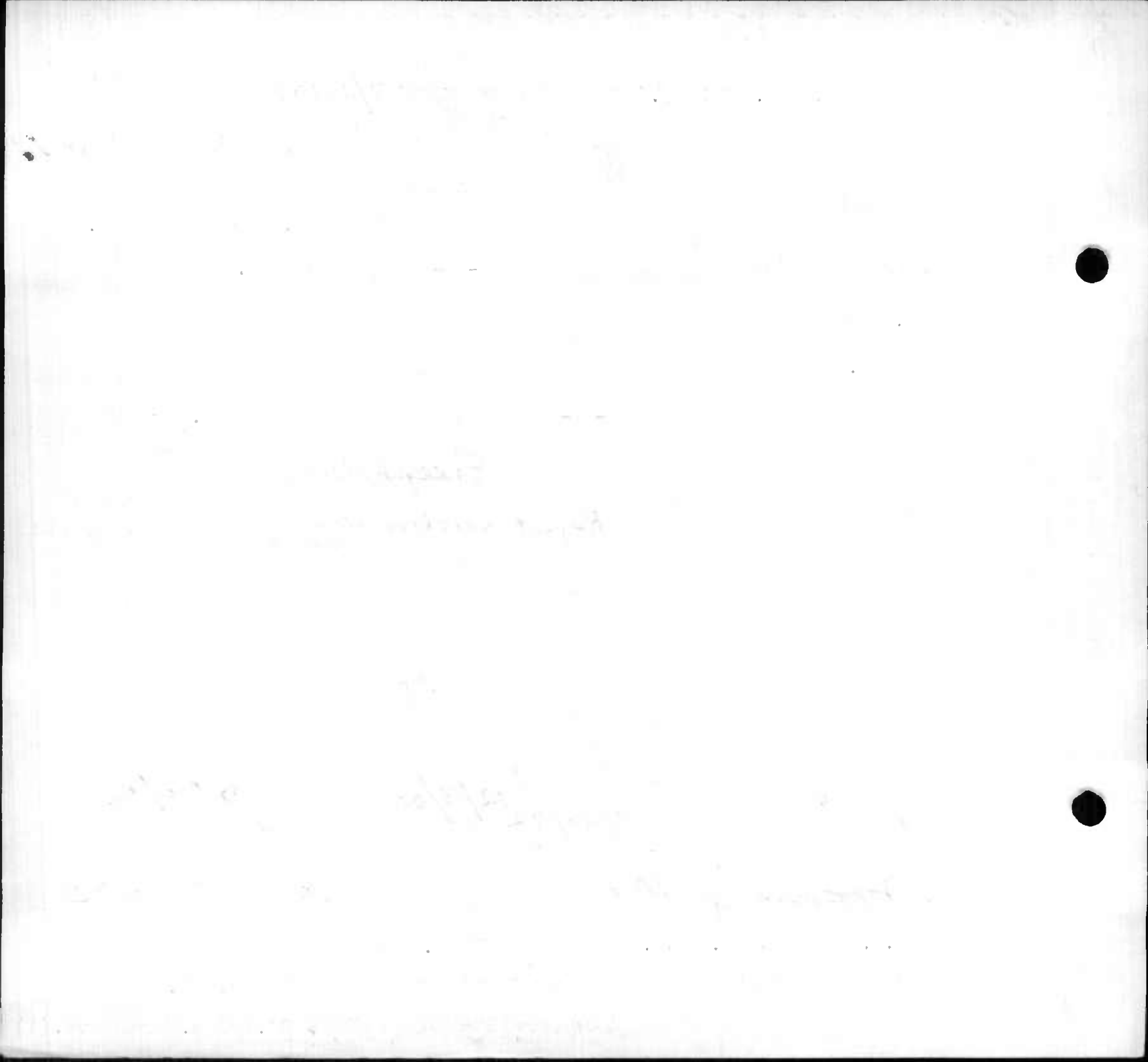
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07288 | | REG. NO. 72 07288 | |
|---|----------------------|---|--|--|---|--|--|
| BIRTH NO. 72 07288 | | | | CERTIFICATE OF DEATH | | STATE OF MARYLAND-DMH | |
| 1. NAME OF DECEASED (Type or Print) Mrs. Mary Burr Pieters | | | | 2. DATE AND HOUR OF DEATH 7-28-72 - 6:00 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 19 Seton Psychiatric Institute 6400 Wabash Avenue Baltimore, Maryland 21215 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY District of Columbia C. CITY OR TOWN D. INSIDE CITY LIMITS? Washington YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1921 Kalorama Road, N.W. | | | |
| 5. SEX Female | 6. RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-4-1882 | 9. AGE (In years last birthday) 90 | 10. If Under 1 Yr. Months: Days: Hours: Min. | 11. If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Martinsburg, West Virginia | | 12. CITIZEN OF WHAT COUNTRY? United States |
| 13. FATHER'S NAME Frank A. Burr | | | 14. MOTHER'S MAIDEN NAME Emma J. Maloney | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. 579-16-3550D | | 17. INFORMANT Hospital Records | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last | | | (A) IMMEDIATE CAUSE Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: (B) Generalized arterio sclerosis with doronary heart disease (C) Chronic brain syndrome associated to arterio sclerosis | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs. |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-15-58 19 to 7-28-72 19 that (H) (we) last saw the deceased alive on July 28 19 72 and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE  | | | | 23B. DATE SIGNED | | | |
| 23C. PHYSICIAN'S NAME (Type) Edmundo Larranaga, M.D. | | | | 23D. ADDRESS 6400 Wabash Avenue, Balto., Md. 21215 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/1/72 | | 24C. NAME OF CEMETERY or CREMATORY St. Joseph's Cemetery | | 24D. LOCATION (City, town, or county) (State) Martinsburg, W. Va. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR Sidney H. Heston | | 25C. FUNERAL DIRECTOR STEWART & HOWEN CO. 108 W. North Ave. (1) | | | |



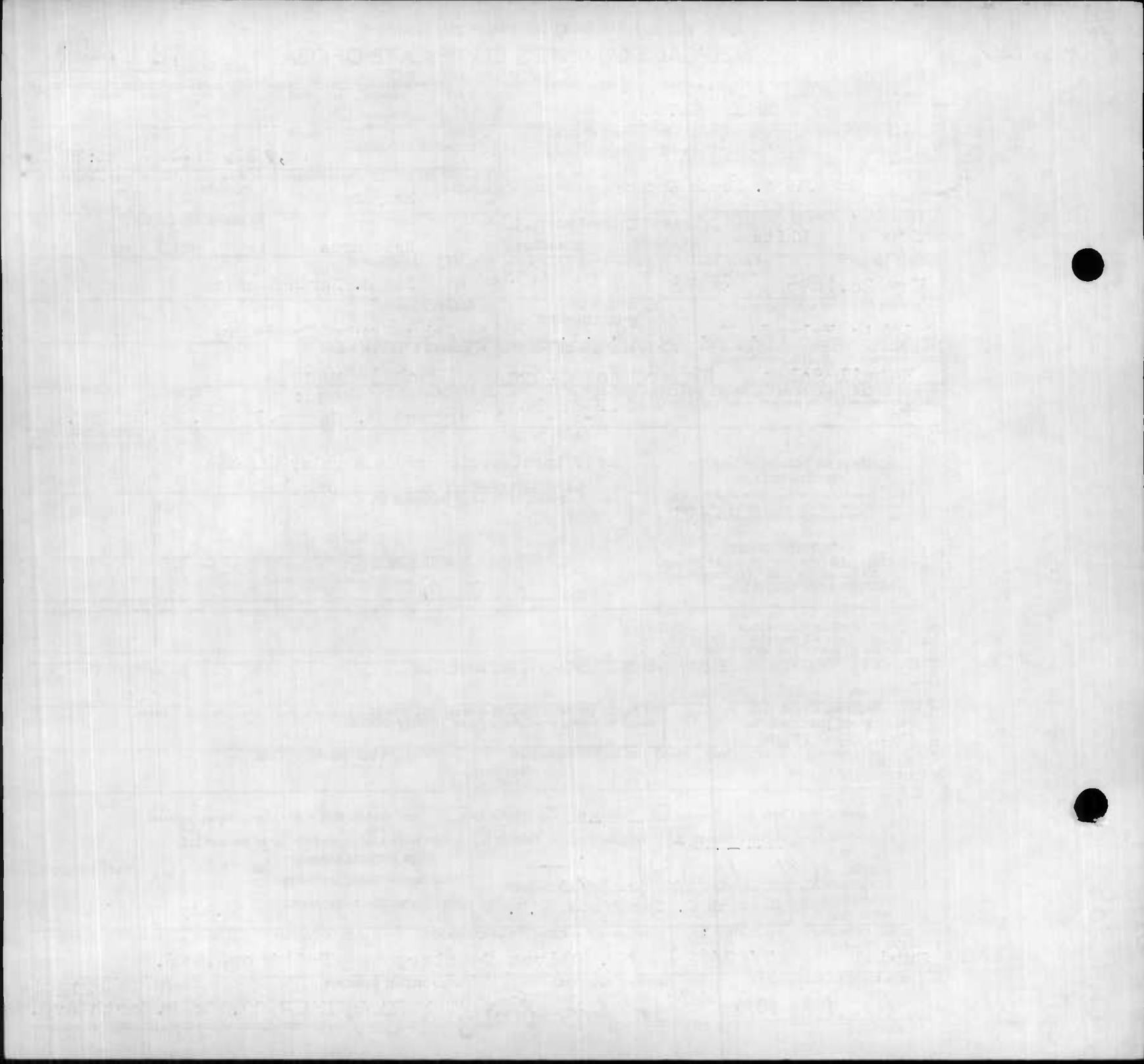
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | 72 07289 | | 72 07289 | |
|---|---------|--|---|--|--------------------------------|
| CERTIFICATE OF DEATH | | | | REG. NO. | |
| STATE OF MARYLAND-DEMD | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | KRUG, MRS. ELSIE G. (ELSIE AUGUSTA KRUG) | | 7/28/72 12 ³⁰ A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE B. COUNTY | | |
| 91 KESWICK | | | MARYLAND BALTIMORE COUNTY | | |
| | | | C. CITY OR TOWN D. INSIDE CITY LIMITS? | | |
| | | | Baltimore YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| | | | E. STREET AND NUMBER | | |
| | | | HAMPTON HOUSE APTS. 204 E JOPPA RD. | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days |
| Female | White | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 6-20-1889 | 83 yrs. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| REG. NURSE | | NONE | | MARYLAND | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| JOHN H. GROSS | | | CAROLINE KROEBER | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 216-01-1803 | | KESWICK RECORDS 700 W. 40th STREET | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>(A) IMMEDIATE CAUSE</p> <p>Due to, or as a consequence of:</p> <p><i>Encephalomalacia</i></p> <p>(B) Repeat cerebrovascular accidents</p> <p>Due to, or as a consequence of:</p> <p>(C)</p> </div> <div style="width: 10%; text-align: center;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p>} about 6 years</p> </div> </div> | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (this hospital) attended the deceased from 12/3/68 19 to 7/28/72 19 that (we) last saw the deceased alive on 7/28/72 19 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| W.B. Daniels, Jr., M.D. | | | | 7/28/72 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| W.B. DANIELS, JR., M.D. | | | | 700 W. 40th STREET | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 7/31/72 | | Loudon Park Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| | | | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| AUG 2 1972 | | Sidney Winston | | STEWART & MOWEN CO. 108 W. North Ave. (1) | |



REG. NO.

VS 151-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 07291

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Estelle Butler

2. DATE AND HOUR OF DEATH

7/20/72

11-15 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Lutheran Hospital of Md.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

md.

C. CITY OR TOWN

Balto

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

3235 Pressman ST.

5. SEX

Female

6. RACE

Negro

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

2-15-03

9. AGE (In years last birthday)

69 yrs

10. Under 1 Yr.

Months Days

11. Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas Green

14. MOTHER'S MAIDEN NAME

Mary E. Brooks

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Chart

ADDRESS

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

POSSIBLE MASSIVE PULMON

ARYEMBOISM

(B)

DUE TO, OR AS A CONSEQUENCE OF:

MYOCARDIAL INFARCTION

(C)

DUE TO, OR AS A CONSEQUENCE OF:

ATRIAL FIBRILLATION

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/10/72 to 7/20/72 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

E. SANDOZ

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

7/20/72

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/25/72

24C. NAME of CEMETERY or CREMATORY

John Wesley Church Cem.

24D. LOCATION

Aguasco Pr. Geo. Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 2 1972

25B. NAME OF REGISTRAR

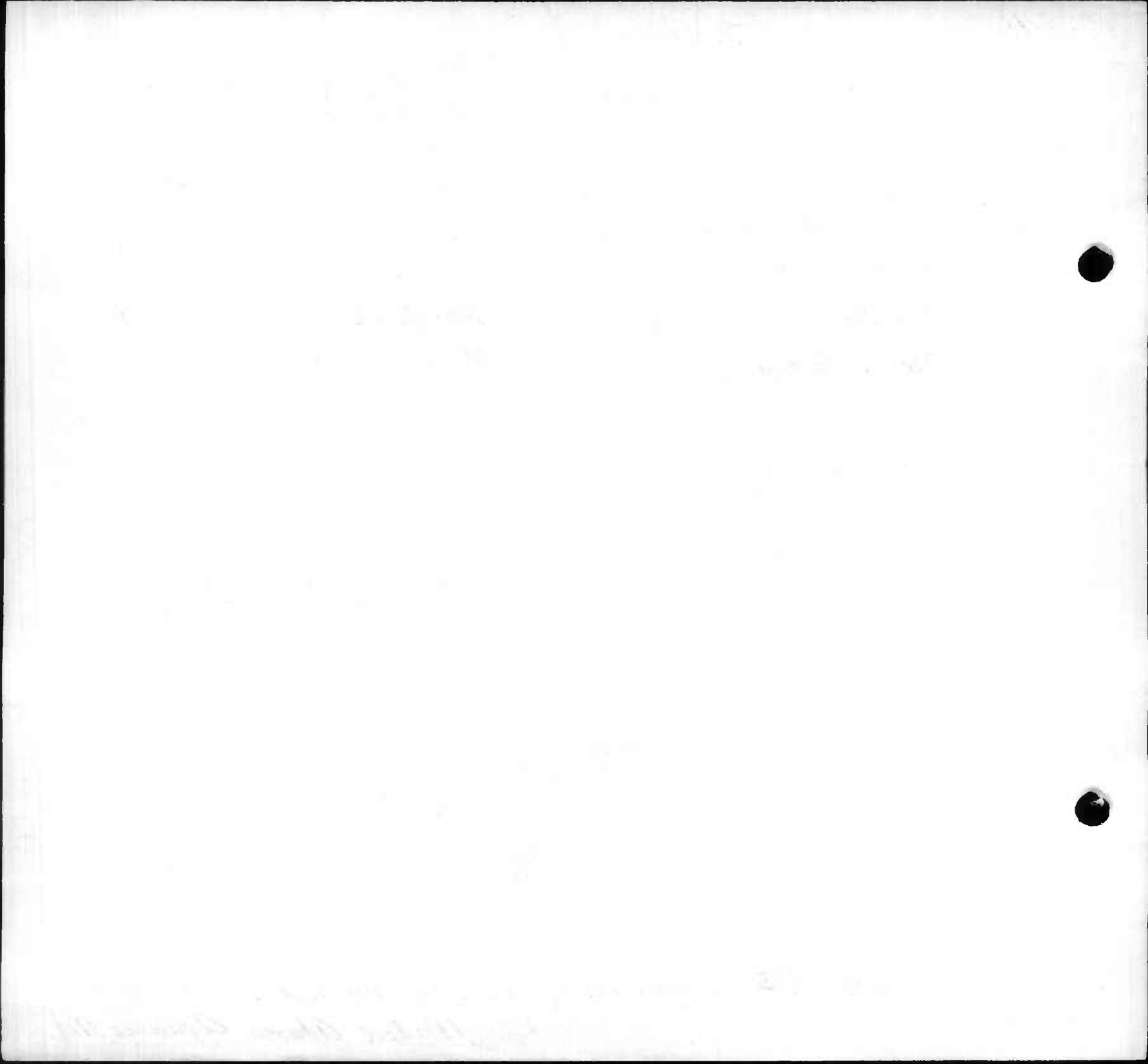
J. J. J. J. J.

25C. FUNERAL DIRECTOR

Marteen Adams

25D. ADDRESS

Aguasco, Md.



FUNERAL DIRECTOR: IMPORTANT

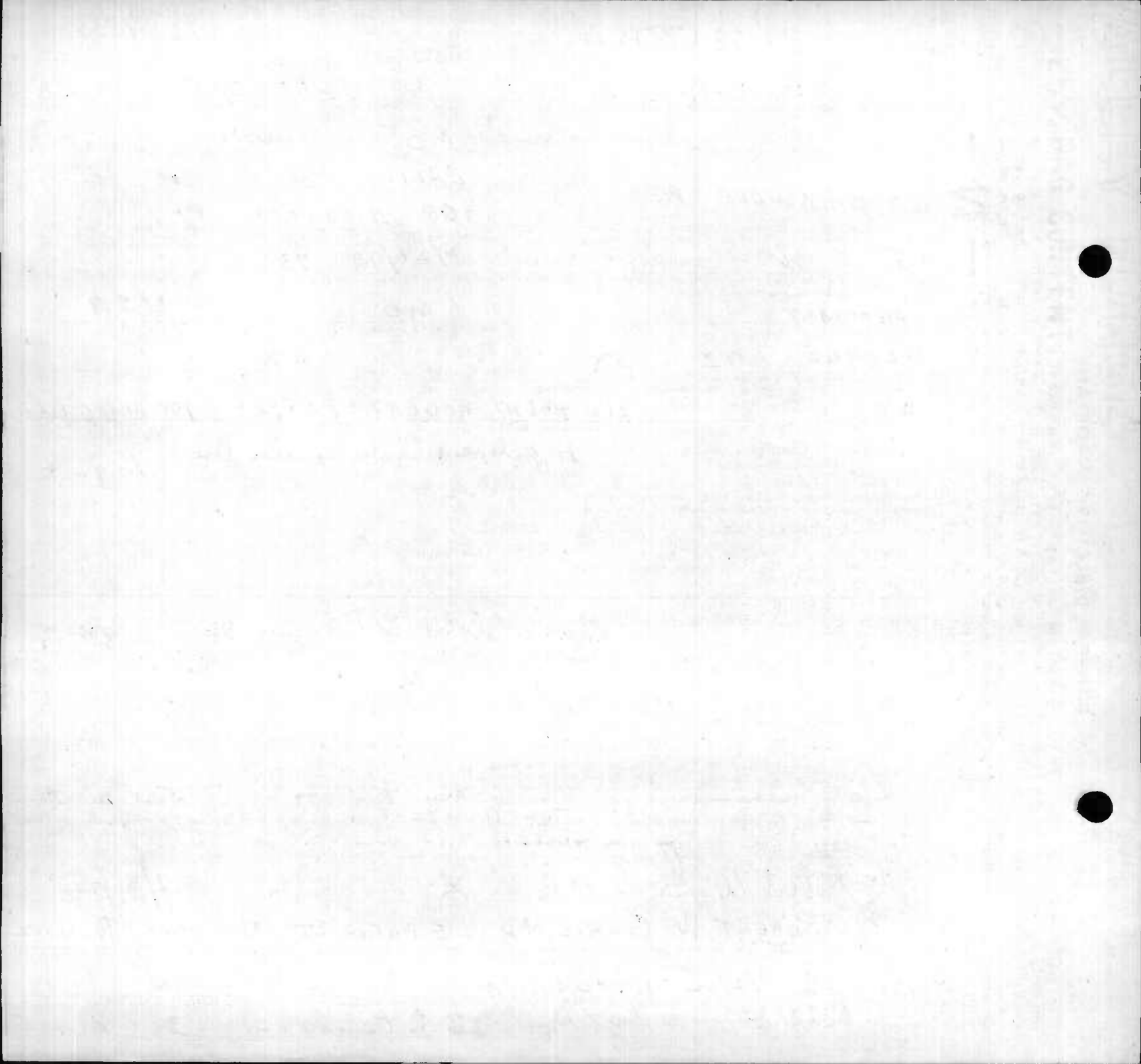
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 72 07292 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07292 | |
|---|-------------------------|---|---|---|--|---|--|
| CERTIFICATE OF DEATH | | | | STATE OF MARYLAND-DEMH | | | |
| 1. NAME OF DECEASED (Type or Print) Margaret Hobbs | | | | 2. DATE AND HOUR OF DEATH July 23, 1972 M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital 44 | | | | A. STATE Maryland | | B. COUNTY 1202 | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 3124 Guilford Avenue | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 23, 1886 | | 9. AGE (In years last birthday) 86 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Forelady | | 10B. KIND OF BUSINESS OR INDUSTRY Franklin Sq. Hospital | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Lawrence W. Hobbs | | | | 14. MOTHER'S MAIDEN NAME Mary A. Renehan | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 210-07-9742 | | 17. INFORMANT L. J. Winter | | ADDRESS Chevy Chase, Maryland | |
| 18. CAUSE OF DEATH 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Heart Dis. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 Yrs. | |
| | | | | (B) Age DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (C)..... | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 19 50 to July 23, 19 72 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Morris B. Schreiber</i> | | | | | | 23B. DATE SIGNED 7-25-72 | |
| 23C. PHYSICIAN'S NAME (Type) Morris B. Schreiber, M.D. | | | | 23D. ADDRESS 1519 W. Lombard St., Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-26-72 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR <i>Andrew Johnston</i> | | 25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home | | ADDRESS 6500 York Road | |

FUNERAL DIRECTOR: IMPORTANT

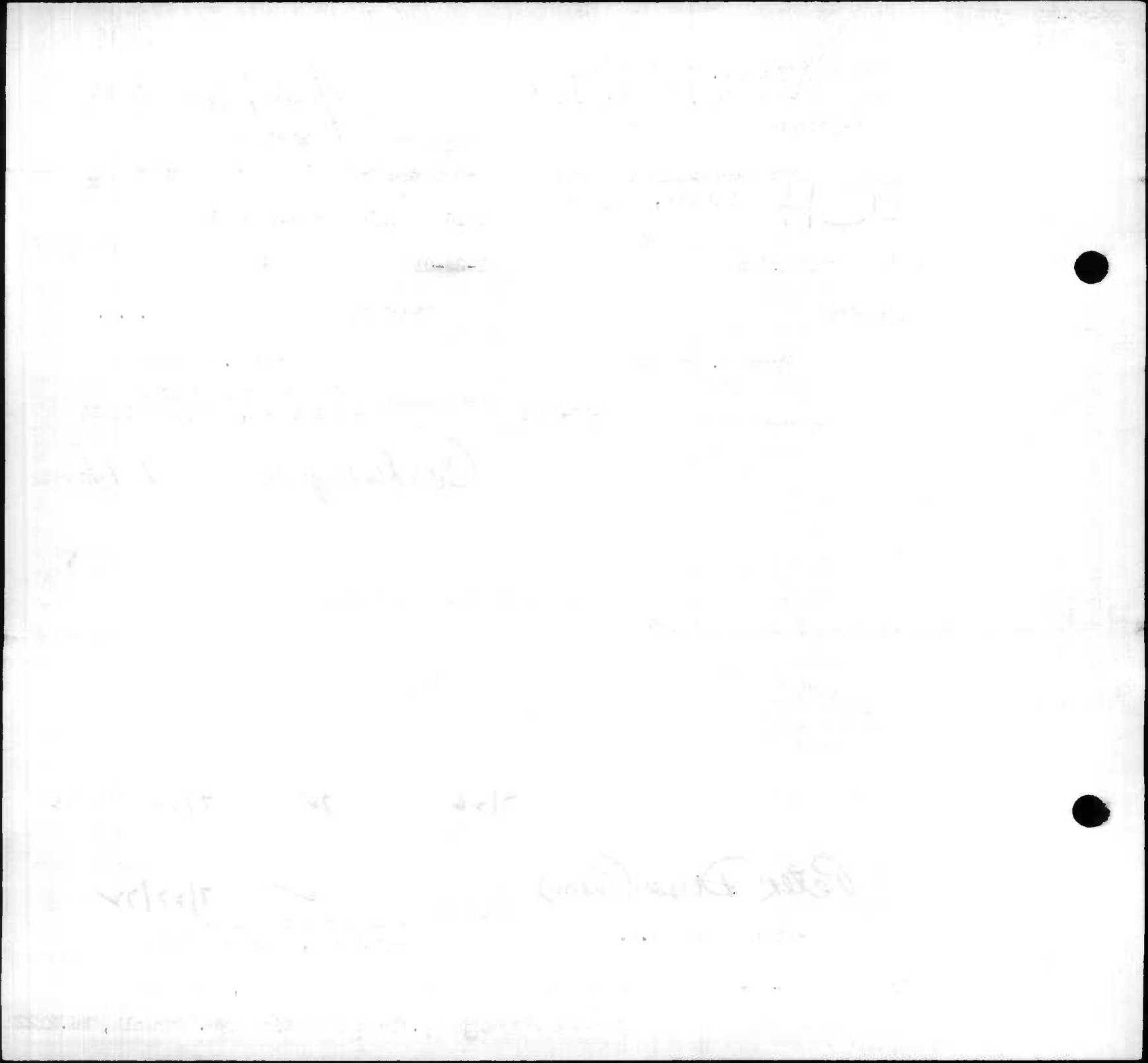
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|
| 72 07293 CERTIFICATE OF DEATH | | | | | REG. NO. 72 07293 | | | | |
| BIRTH NO. | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| 1. NAME OF DECEASED (Type or Print) GLADYS C. BIEW | | | | | 2. DATE AND HOUR OF DEATH JULY 30 1972 2A.M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 308 BIRKWOOD PL. | | | | | A. STATE MD B. COUNTY BALT | | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | | C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 8. DATE OF BIRTH 2/27/99 9. AGE (In years last birthday) 73 | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC | | | | | 11. BIRTHPLACE (State or foreign country) MD | | | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 13. FATHER'S NAME GEORGE LITZ SR | | | | | 14. MOTHER'S MAIDEN NAME VANK | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | | 16. SOCIAL SECURITY NO. 212-40-0417 | | | | |
| 17. INFORMANT ROBERT POFFEL | | | | | ADDRESS 100 MARGARET | | | | |
| 18. 412.32 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Hypertensive Cardiovascular Dis. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 yrs. + | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic Obstructive Pulmonary Dis. | | | | | 8 yrs. + | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | |
| 20A. AUTOPSY? (Yes or No) No | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from AUG. 7 1944 to JULY 30 1972 , that (I) (we) last saw the deceased alive on JULY 11 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Robert W. Garis, M.D. | | | | | 23B. DATE SIGNED 7/31/72 | | | | |
| 23C. PHYSICIAN'S NAME (Type) ROBERT W. GARIS, M.D. | | | | | 23D. ADDRESS 12 E. EAGER ST., BALTIMORE, MD. 21202 | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | | 24B. DATE 7/2/72 | | | | |
| 24C. NAME OF CEMETERY OR CREMATORY WOODLAWN | | | | | 24D. LOCATION (City, town, or county) (State) BALTO. MD. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | | | | 25B. NAME OF REGISTRAR Andrey Andronov | | | | |
| 25C. FUNERAL DIRECTOR J. G. CORNELLY | | | | | ADDRESS 300 MACE | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | |
|--|--|--|--|--|--|
| 72 07294 | | 72 07294 | | 72 07294 | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | |
| Viola C. Pettie | | 7/26/72 1:00 PM | | Baltimore City Hospital | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | 5. SEX | |
| 31 BC H 4940 Eastern Avenue Baltimore, Maryland | | A. STATE B. COUNTY Maryland Baltimore | | Female Caucasian | |
| 6. CITY OR TOWN | | 7. INSIDE CITY LIMITS? | | 8. MARRIED | |
| Baltimore Edgemere | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| E. STREET AND NUMBER | | 9. AGE (In years last birthday) | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 2505 Veronica Avenue 21219 | | 71 | | Housewife | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | |
| Virginia | | U.S.A. | | Frank C. Campbell | |
| 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| Mary E. Skelton | | NO | | 214-20-9001 | |
| 17. INFORMANT | | 18. CAUSE OF DEATH | | 19. DATE OF OPERATION | |
| BCH Records 4940 Eastern Avenue Baltimore, Maryland 21224 | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | 20A. AUTOPSY? (Yes or No) | |
| | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiorenal Arrest. 1 Hour | | NO | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) | |
| | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 7/26 1972 to 7/26 1972 that (I) (we) last saw the deceased alive on 7/26 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE Peter Dorsen (Enclon) | | 23B. DATE SIGNED 7/27/72 | | 23C. PHYSICIAN'S NAME (Type) | |
| Peter Dorsen M.D. | | | | 23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 7-31-72 | | Gardens of Faith Cemetery | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | |
| Baltimore, Maryland | | AUG 2 1972 | | John J. Duda | |
| 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | | 25E. ADDRESS | |
| John J. Duda | | 7922 Wise Ave. Dundalk, Md. 21222 | | | |



72 07295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH
STATE OF MARYLAND-DEATH

REG. NO. 72 07295

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Elswick, Olie M.

2. DATE AND HOUR OF DEATH

July 29, 1972

11:10pm.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN

Dundalk

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1918 Inverton Road

5. SEX

Female

6. RACE

Caucasian

7. MARRIED

NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

Feb. 1, 1931

9. AGE (In years
last birthday)

41

If Under 1 Yr.
MonthsIf Under 1 Yr.
DaysIf Under 24 Hrs.
HoursIf Under 24 Hrs.
Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VA

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Olive B. Osborne

14. MOTHER'S MAIDEN NAME

Leona White

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

BCH-Records

ADDRESS
4940 Eastern Avenue

Baltimore, Maryland 21224

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Subarachnoid hemorrhage

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

4 days

life

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

No

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

No

21C. WHERE DID
INJURY OCCUR?

No

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

No

21E. INJURY OCCURRED

No

While At
WorkNot While
At Work

21F. HOW DID INJURY OCCUR?

No

22. I certify that (I) (this hospital) attended the deceased from 7-25 19 72 to 7-29 19 72
that (I) (we) last saw the deceased alive on 7-29 19 72 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Karl Stecher Jr. M.D.

Attending
Phys.Med.
DirectorStaff
Phys. ☒

23B. DATE SIGNED

7-29-72

23C. PHYSICIAN'S
NAME (Type)

Karl Stecher Jr. M.D.

23D. ADDRESS

4940 Eastern Avenue
Baltimore, Maryland 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/1/72

24C. NAME OF CEMETERY OR CREMATORY

Green Hill Memory Gardens

24D. LOCATION

(City, town, or county)

Claypool, Virginia

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 2 1972

25B. NAME OF REGISTRAR

John J. Luda

25C. FUNERAL DIRECTOR

John J. Luda

ADDRESS

7922 Wise Ave. Dundalk, Md

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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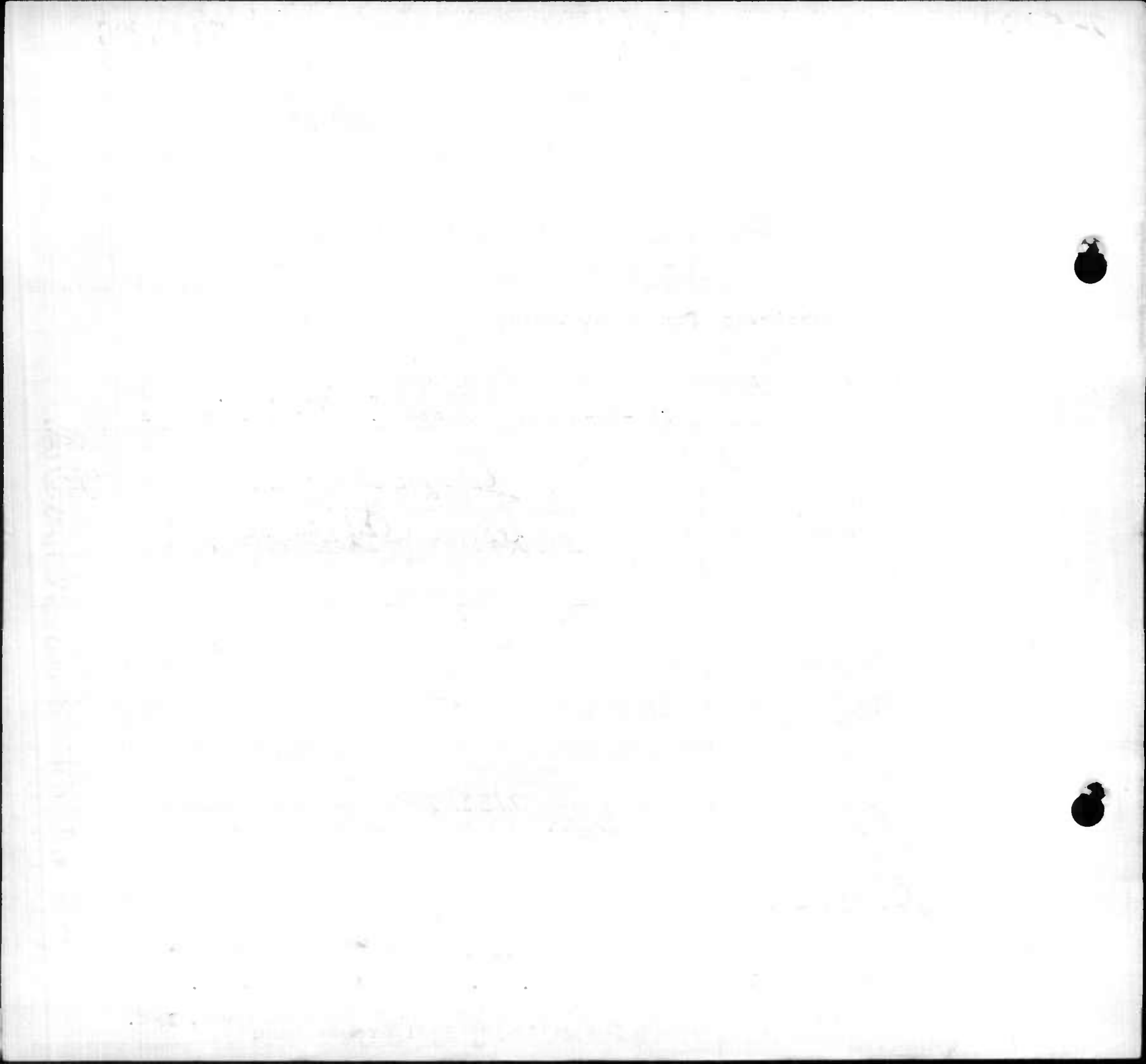
10-10-10

10-10-10

10-10-10

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-----------------------------|---|--|---|--|
| <p>7-520-1</p> <p>S-324</p> <p>72 07296</p> | | <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p> | | <p>REG. NO. 72 07296</p> | |
| <p>BIRTH NO.</p> | | <p>1. NAME OF DECEASED STIEGLER</p> | | <p>2. DATE AND HOUR OF DEATH DECEASED / 29 / 72</p> | |
| <p>(Type or Print) Stiegler, August Thomas</p> | | <p>STATE OF MARYLAND</p> | | <p>8:25 ^{am} M.</p> | |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> | | <p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> | | <p>A. STATE Maryland</p> | |
| <p>FULL NAME OF HOSPITAL OR INSTITUTION +9</p> | | <p>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) North Charles Gen. Hosp.</p> | | <p>B. COUNTY 702</p> | |
| <p>C. CITY OR TOWN Baltimore</p> | | <p>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> | | <p>E. STREET AND NUMBER 716 N. Luzerne Avenue</p> | |
| <p>5. SEX Male</p> | <p>6. RACE White</p> | <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p> | <p>8. DATE OF BIRTH 1/24/06</p> | <p>9. AGE (In years last birthday) 66</p> | <p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p> |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Upholster</p> | | <p>10B. KIND OF BUSINESS OR INDUSTRY Fox Upholstering</p> | | <p>11. BIRTHPLACE (State or foreign country) Md. Baltimore</p> | |
| <p>12. CITIZEN OF WHAT COUNTRY?</p> | | <p>13. FATHER'S NAME Andy Stiegler</p> | | <p>14. MOTHER'S MAIDEN NAME Elizabeth Sima</p> | |
| <p>15. Was Deceased ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no</p> | | <p>16. SOCIAL SECURITY NO. 213-10-2022A</p> | | <p>17. INFORMANT Box 18B - Jessup, Md. 20794 Edward E. Stiegler, brother</p> | |
| <p>18. 45671</p> | | <p>CAUSE OF DEATH</p> | | <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days</p> | |
| <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> | | <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrest possibly due to pulmonary embolus</p> | | | |
| <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> | | <p>(B) Cerebrovascular Accident</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> | | | |
| <p>(C)</p> | | | | | |
| <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Pneumonia</p> | | | | | |
| <p>19A. DATE OF OPERATION</p> | | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> | | <p>20A. AUTOPSY? (Yes or No) No</p> | |
| <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> | | <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p> | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | |
| <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | | <p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p> | | <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | |
| <p>21F. HOW DID INJURY OCCUR?</p> | | <p>22. I certify that (I) (this hospital) attended the deceased from 7/23/72 19 to 7/29/72 19 that (I) (we) last saw the deceased alive on 7/29/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | | | |
| <p>23A. SIGNATURE Robert C. Martin</p> | | <p>23B. DATE SIGNED 7/29/72</p> | | <p>23C. PHYSICIAN'S NAME (Type) no</p> | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p> | | <p>24B. DATE 8/1/72</p> | | <p>24C. NAME OF CEMETERY or CREMATORY Bohemian Nat. Cm.</p> | |
| <p>24D. LOCATION (City, town, or county) (State) Baltimore, Md.</p> | | <p>25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972</p> | | <p>25B. NAME OF REGISTRAR Andrey Petrov</p> | |
| <p>25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.</p> | | <p>25D. ADDRESS 3331 Brehms Lane</p> | | | |



sub-56-23-22]
B-633

72 07297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH
STATE OF MARYLAND-DEMD

REG. NO. 72 07297

| | | | | | |
|--|-------------------------|--|--------------------------------------|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) JAMES BARTON | | 2. DATE AND HOUR OF DEATH 8:55 AM 31 Jul 72 | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md B. COUNTY 1506 | | 5. M. <input type="checkbox"/> | |
| FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITAL | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | E. STREET AND NUMBER 4940 Eastern Ave. Baltimore City Hospitals 21224 | | | |
| 5. SEX M | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 19 MAR 01 | 9. AGE (In years last birthday) 71 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | 10B. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA | |
| 13. FATHER'S NAME ? | | 14. MOTHER'S MAIDEN NAME ? | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ? | | 16. SOCIAL SECURITY NO. 312-05-2500 | | 17. INFORMANT Edward Coates 2308 Euting St. Records: BCH-4940 Eastern Ave. 21224 | |

| | | | | | |
|---|--|--|--|--|--|
| 18. 72 07297 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). - | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: C.V.A. (recurrent) (B) Cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) - | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH - 1970 - | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 70 19 to 31 Jul 72 19, that (I) (we) last saw the deceased alive on 31 Jul 72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Edmund S. Beacham MD | | | | 23B. DATE SIGNED 31 Jul 72 | |
| 23C. PHYSICIAN'S NAME (Type) E. G. BEACHAM M.D. | | | | 23D. ADDRESS 4940 Eastern Avenue, Baltimore, Md. BALTO CITY HOSPS. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-4-72 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. | |
| 24D. LOCATION (City, town, or county) (State) Balto., Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR Sidney H. [Signature] | | 25C. FUNERAL DIRECTOR V. Bailey Nelson F. H. 1348 Calhoun Street | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

2914 Wai brook Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>72 67298</u> |
|---|--|--|--|---|
| 72 67298 | | | | CERTIFICATE OF DEATH |
| STATE OF MARYLAND - DEMO | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>Henry Cockrell</u> | | |
| 2. DATE AND HOUR OF DEATH <u>7-29-72</u> | | M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1605</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u> <u>2533 W. Lafayette Ave.</u> | | C. CITY OR TOWN <u>Balto.</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX <u>Male</u> 6. RACE <u>Negroid</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1-30-72</u> | | 9. AGE (In years last birthday) <u>100</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Va.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Moses Cockrell</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Fannie Hudnell</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Laura Hale</u> same | | |
| 18. <u>412.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic Heart Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>a week</u> <u>204 yrs.</u> |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9/20/1960</u> 19 <u>72</u> to <u>July 29</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>July 29</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <u>Jos. N. Zierler</u> | | | | 23B. DATE SIGNED |
| 23C. PHYSICIAN'S NAME (Type) <u>Jos. N. Zierler</u> | | | | 23D. ADDRESS <u>2502 Euter Place</u> <u>Balt 21217</u> |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>8-5-72</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u> |
| 24D. LOCATION (City, town, or county) (State) <u>Northumberland Co., Va.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 2 1972</u> | | |
| 25B. NAME OF REGISTRAR <u>Andrew H. Hooton</u> | | 25C. FUNERAL DIRECTOR <u>V. Bailey</u> <u>Kelson F.H.</u> | | |
| ADDRESS <u>1348 Calhoun Street</u> | | | | |



1
J-520

72 07239 BALTIMORE CITY HEALTH DEPARTMENT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07239

BIRTH NO.

STATE OF MARYLAND-DEMD

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) ALTON JONES | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1631 Pennsylvania Ave. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 31 1972 12:45a M. | |
| 6. SEX male | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1402 | |
| 7. RACE negro | | C. CITY OR TOWN Balto. | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH 10-28-17 | | 10. AGE (In years last birthday) 54 | |
| 11. BIRTHPLACE (State or foreign country) Va. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Henderson Jones | | 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plummie Butler | |
| 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT John Jones | | ADDRESS 2312 Ruskin Ave. | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Hypertensive & arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 22A. DATE OF OPERATION | | 22B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22C. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22E. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22F. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22G. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22H. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Marvin S. Platt, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-31-72 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-7-72 | |
| 24C. NAME OF CEMETERY or CREMATORY Church Cem. | | 24D. LOCATION (City, town, or county) (State) Windsor, Va. | |
| 25A. DATE REC'D BY HEALTH DEPT AUG 2 1972 | | 25B. NAME OF REGISTRAR Andrew H. Houston | |
| 25C. FUNERAL DIRECTOR V. Bailey | | ADDRESS Kelson F.H. 1348 Calhoun Street | |

ST-10-5

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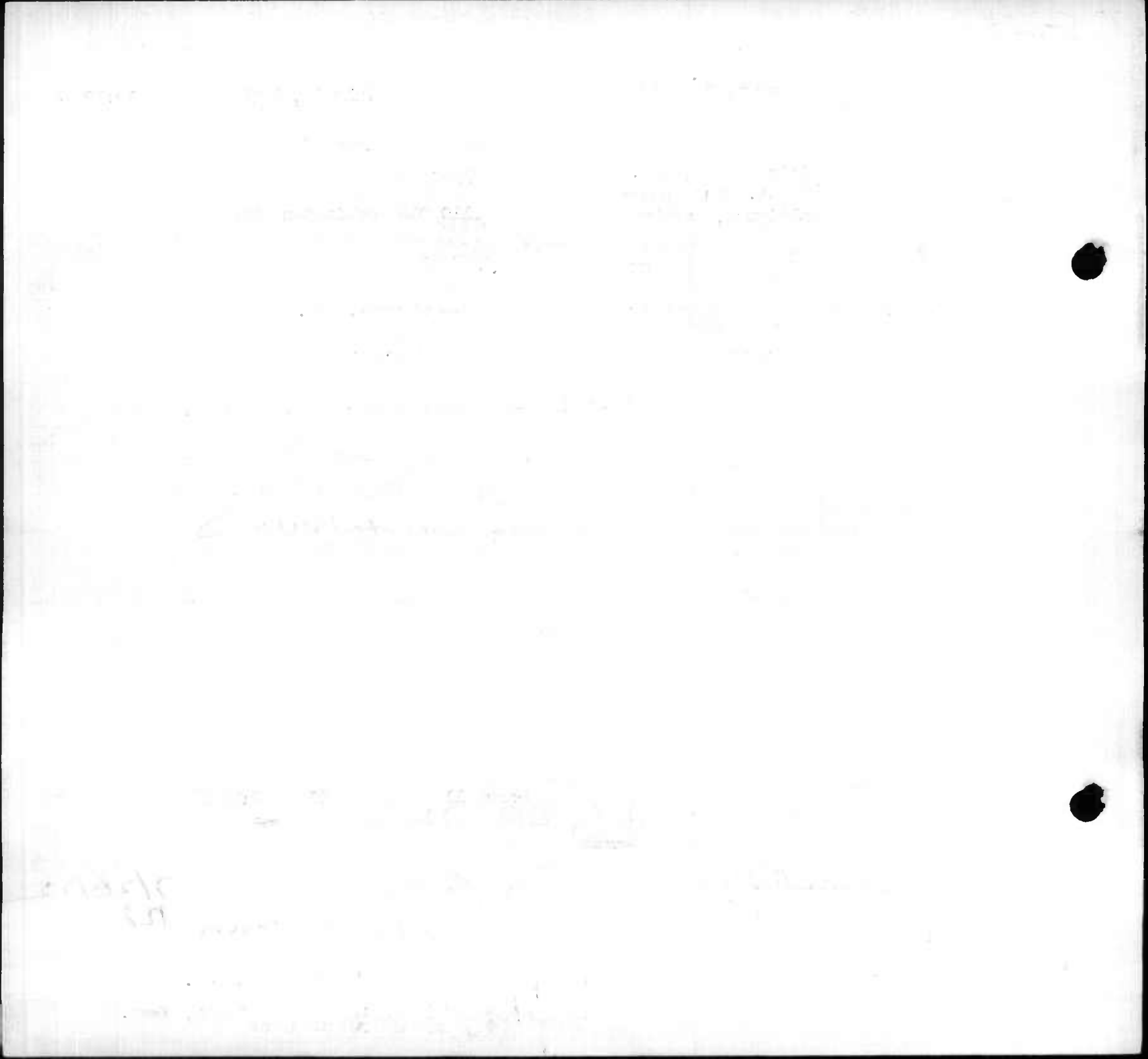
ST-10-5

ST-10-5

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

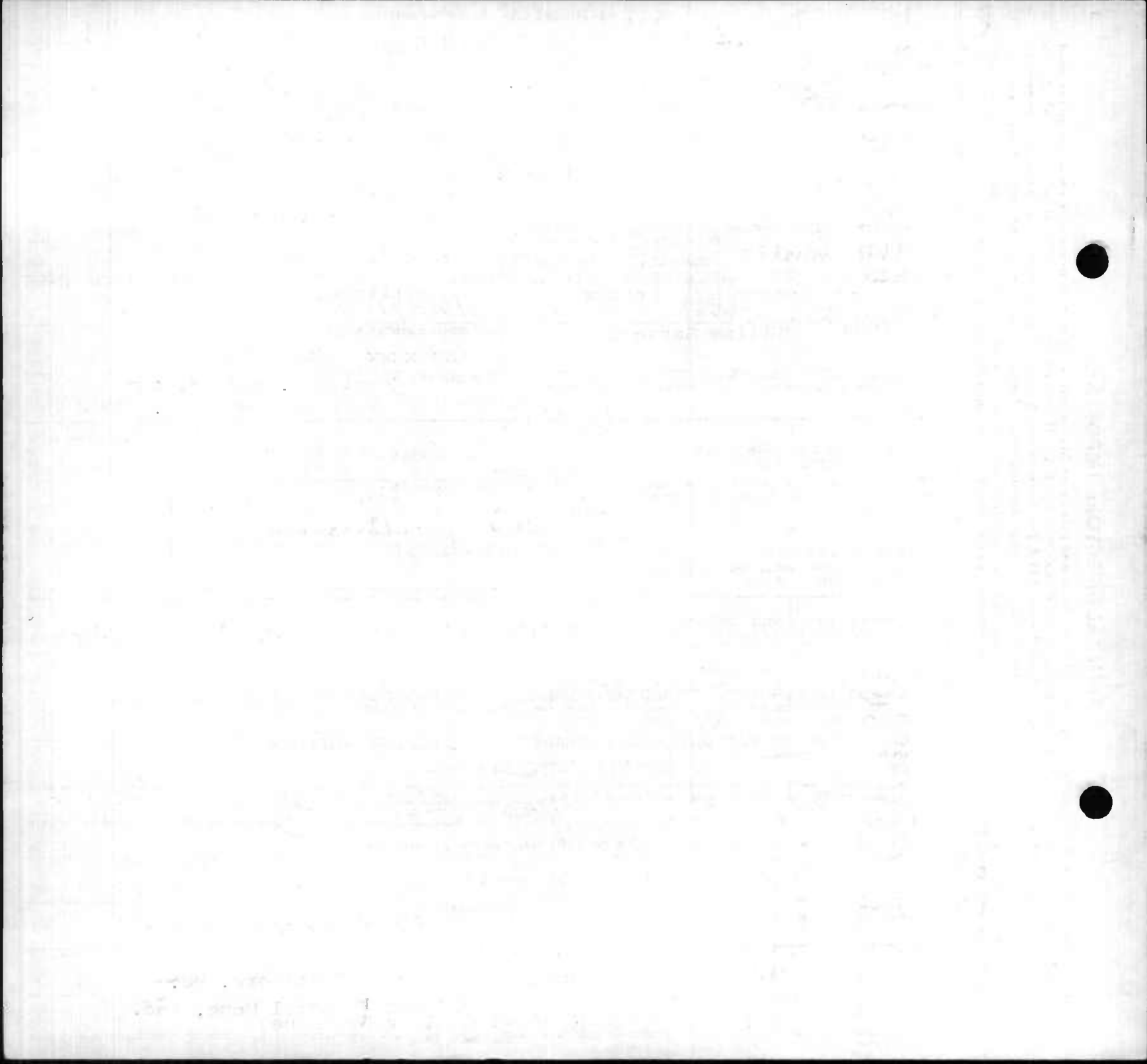
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | |
|--|--|---|--|--|--|
| 72 07300 | | 72 07300 | | 72 07300 | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | |
| Margaret STANT | | July 28, 1972 10:10 A.M. | | FULL NAME OF HOSPITAL OR INSTITUTION Midtown Home, Inc. 808 St. Paul Street Baltimore, Maryland | |
| 4. SEX | | 5. RACE | | 6. MARRIED | |
| F | | C | | NEVER MARRIED | |
| 7. WIDOWED | | 8. DIVORCED | | 9. DATE OF BIRTH | |
| X | | | | 8/20/92 | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? | |
| Housewife | | at home | | Baltimore, Md. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? | |
| Herbert | | unknown | | (Yes, no or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 218-03-1799-D | | Bertha Sommers, friend, above | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) | | Cardio-Respiratory Failure | | | |
| ANTECEDENT CAUSES | | (A) IMMEDIATE CAUSE | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| II | | Senility | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from March 11 1971 to July 28 1972 | | 22. I certify that (I) (this hospital) attended the deceased from March 11 1971 to July 28 1972 | | 22. I certify that (I) (this hospital) attended the deceased from March 11 1971 to July 28 1972 | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) | |
| William D. Applefeld | | 7/28/72 | | William D. Applefeld | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 7/31/72 | | Baltimore Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| AUG 2 1972 | | Sidney Ingham | | Schimunek Funeral Home, Inc. | |
| | | | | 3331 Brehms Lane | |



FUNERAL DIRECTOR: IMPORTANT

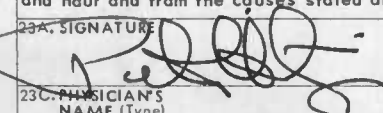
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

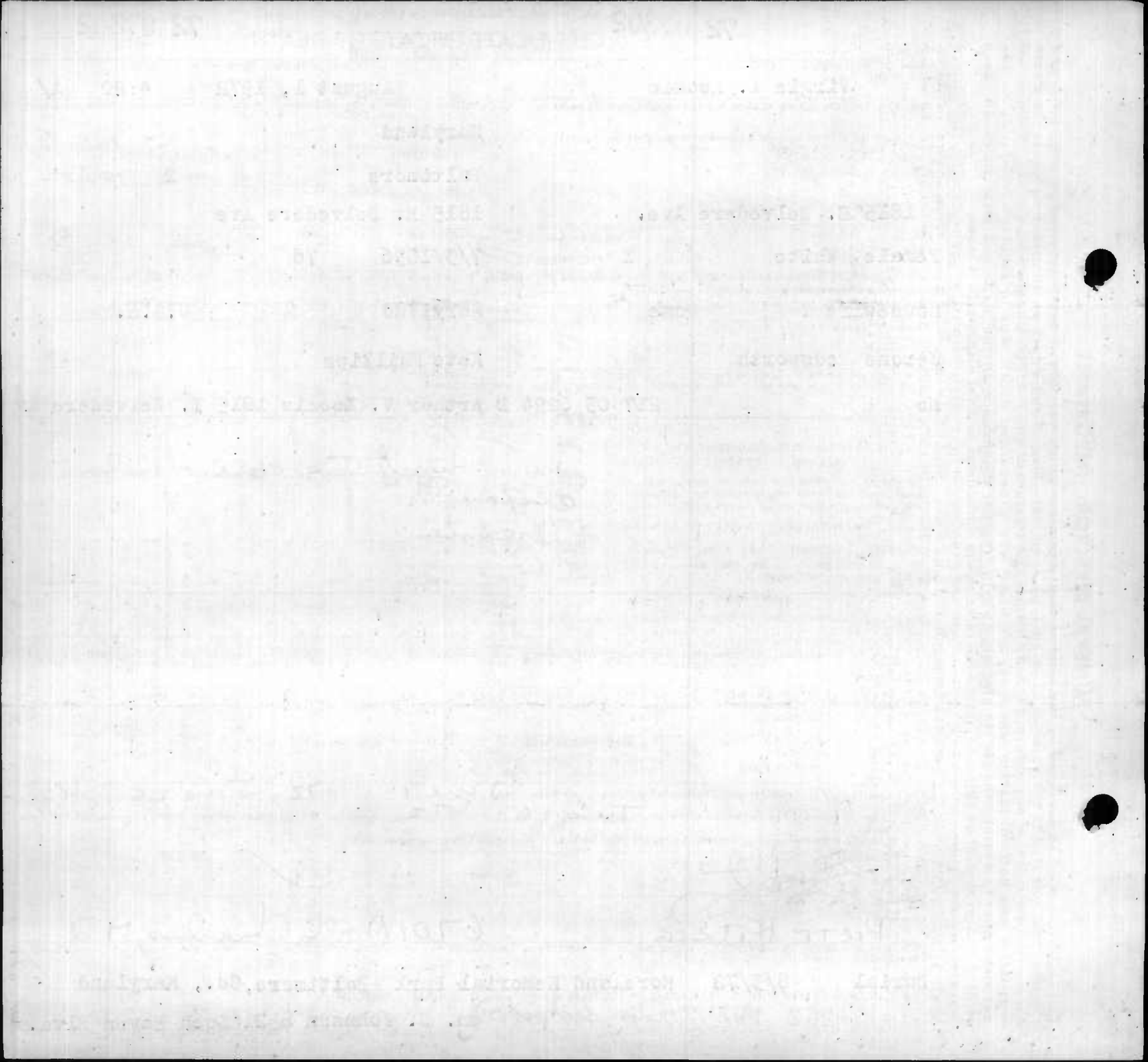
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|---|--|---|--|--|---|--|--|
| 72 07301 | | | | | 72 07301 | | | | |
| BIRTH NO. SASSCER | | | | | REG. NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) SASSER, William J. | | | | | 2. DATE AND HOUR OF DEATH July 28, 1972 8:00 P.M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 21224 | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND General Hospital | | | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| E. STREET AND NUMBER 413 N. Glover St | | | | | | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9/8/92 | 9. AGE (in years last birthday) 79 | 10. Under 1 Yr. Months: Days: Hours: Min. | | 11. Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DAIRY WORKER - retired | | | | | 10B. KIND OF BUSINESS OR INDUSTRY DAIRY | | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | |
| 13. FATHER'S NAME William Sasscer Unknown | | | | | 14. MOTHER'S MAIDEN NAME Katherine | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | | 16. SOCIAL SECURITY NO. 212-10-8679 | | 17. INFORMANT Charles W. Sasscer, son CHART 3021 Woodhome Ave. 21234 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) GASTRIC CARCINOMA with metastases to liver, omentum and peritoneum | | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: metastases to liver, omentum and peritoneum (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Cerebro-vascular accident | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II Cerebro-vascular accident | | | | | 20. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 2 days | | | | |
| 19A. DATE OF OPERATION 7/24/72 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED GASTRIC CARCINOMA | | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from: 6/28 1972 to 7/28 1972 that (I) (we) last saw the deceased alive on 7/28 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Victor J. Kogon | | | | | 23B. DATE SIGNED 7/28/72 | | | | |
| 23C. PHYSICIAN'S NAME (Type) Victor J. Kogon | | | | | 23D. ADDRESS MARYLAND General Hosp | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/1/72 | | 24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR Adrian H. Horton | | 25C. FUNERAL DIRECTOR Schmuck Funeral Home, Inc. | | ADDRESS 3331 Brehms Lane | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07302 |
|---|--|--|--|---|
| 72 07302 | | CERTIFICATE OF DEATH | | STATE OF MARYLAND-DEMD |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) Virgie A. Loomis | | |
| 2. DATE AND HOUR OF DEATH August 1, 1972 | | 4:20 A/M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1815 E. Belvedere Ave. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2758 | | |
| 5. SEX Female | | 6. RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH 7/3/1896 | | 9. AGE (In years last birthday) 76 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Jerome Bedsworth | | 14. MOTHER'S MAIDEN NAME Kate Phillips | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217 03 6294 D | | 17. INFORMANT Arthur V. Loomis |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chemia | | | | |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from June 1 19 72 to June 26 19 72 , that (I) (we) last saw the deceased alive on June 26 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE  | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED |
| 23C. PHYSICIAN'S NAME (Type) Peter Hitzig | | 23D. ADDRESS 6701 North Charles, MD | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/3/72 | | 24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Co., Maryland | | 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | |
| 25B. NAME OF REGISTRAR Sidney Johnson | | 25C. FUNERAL DIRECTOR M. E. Johnson | | |
| ADDRESS 8521 Loch Raven Blvd. | | | | |

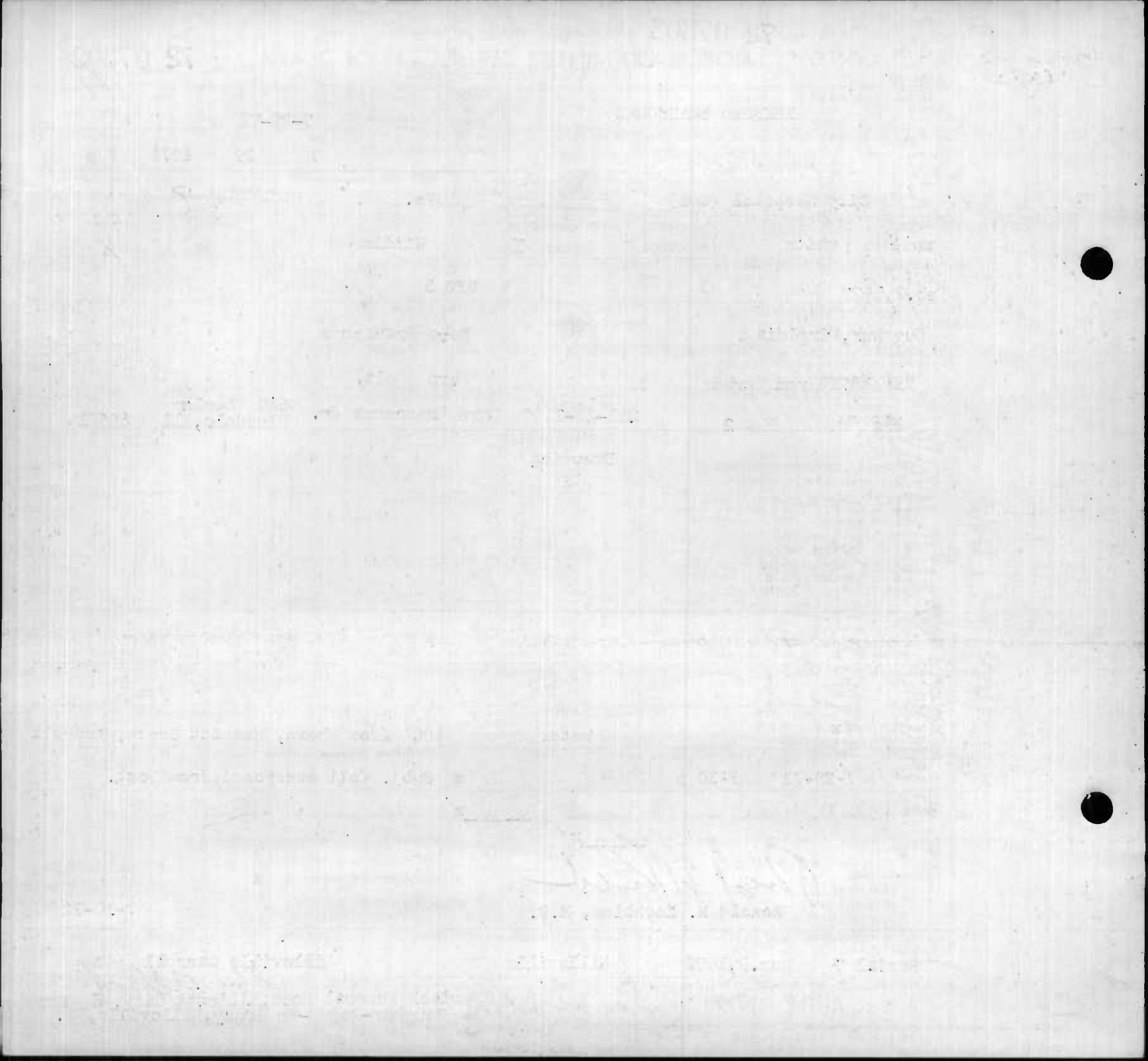


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07303

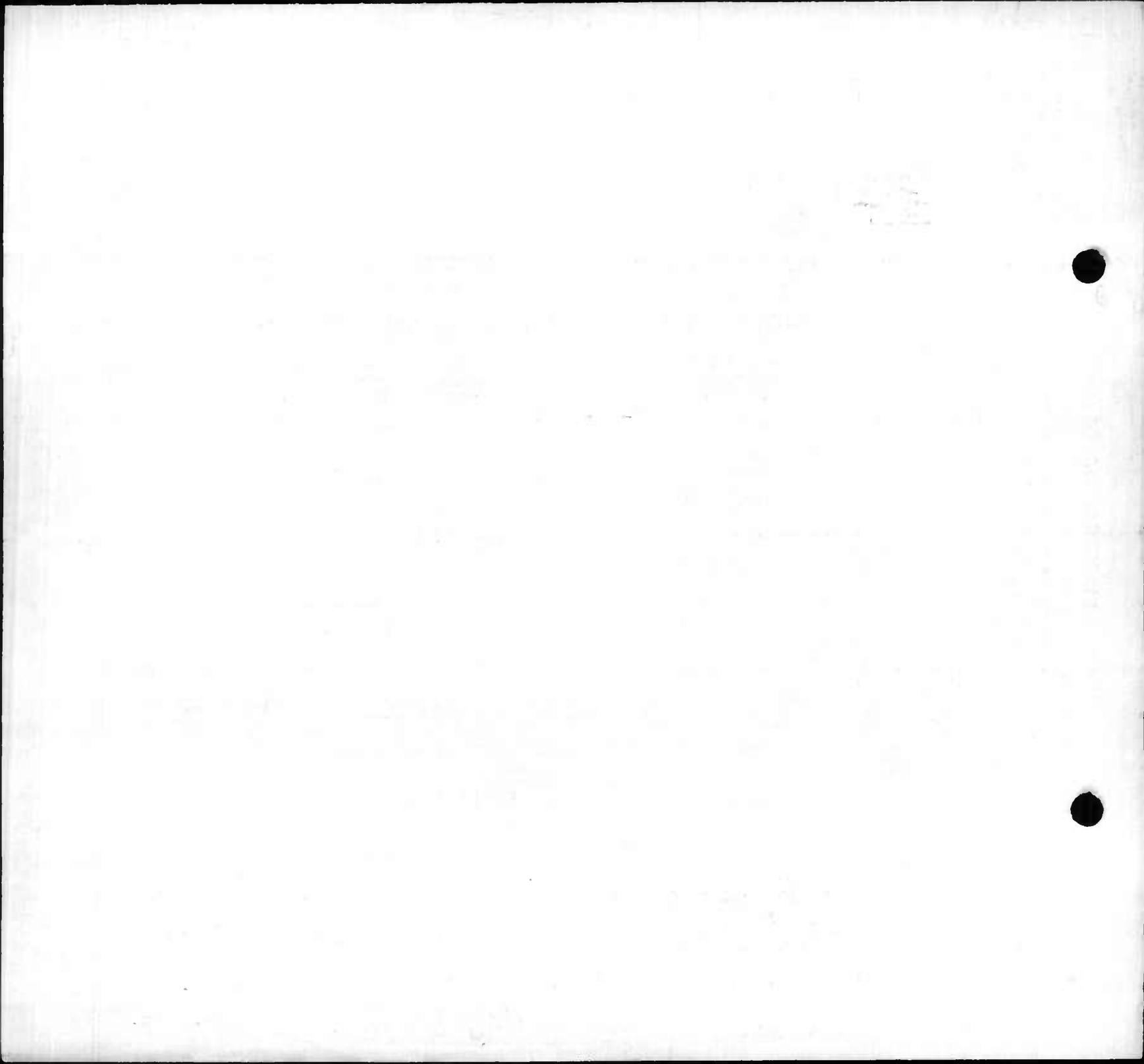
BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) REXFORD BRANSCOME | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 7-29-72 M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) City Hospital (DOA) | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 29 1972 8 p M. | |
| 6. SEX male | | 7. RACE white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | C. CITY OR TOWN Willis | |
| 9. DATE OF BIRTH Feb. 2, 1927 | | 10. AGE (In years lost birthday) 45 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Dugshur, Virginia | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Dave Branscome | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not Known Iron Worker | |
| 15. MOTHER'S MAIDEN NAME Eura Bolt | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW2 | |
| 17. SOCIAL SECURITY NO. 231-42-1197 | | 18. INFORMANT Dave Branscome Jr. 5627 Thurlow Hinsdale, Ill 60521 | |
| 19. CAUSE OF DEATH Drowning | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION 7-29-72 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) water | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 100' from shore, Merritt Beach, Dundalk | | 22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 7-29-72 7:30 p m. | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Subj. fell overboard from boat. | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Ronald N. Kornblum, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED 7-30-72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 7 | | 24B. DATE Aug. 3, 1972 | |
| 24C. NAME of CEMETERY or CREMATORY Hillsville | | 24D. LOCATION (City, town, or county) (State) Hillsville Carroll Va | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR Sidney Johnston | |
| 25C. FUNERAL DIRECTOR Slack Funeral Home, Ellicott City, Md. for Vaughan-Guynn-Mc Grady, Hillsville, Va. | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|---|--|--|--|
| 72 07304 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07304 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | |
| PRICE, William Herbert | | 7-30-72 1930 A.M. | | FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | |
| CHURCH HOME & HOSPITAL, BALTO. | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY | | 5. SEX 6. RACE | |
| 35 | | Md. 703 | | MALE W | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Retired Chauffer | | Baltimore City | | MARYLAND Baltimore | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY | |
| JOSEPH PRICE | | CATHERINE ROSEN Rabeman | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| no | | 217-03-7437 | | Margaret Stroup, sister | |
| 18. CAUSE OF DEATH | | 19. MEDICAL CERTIFICATION | | 20. DATE SIGNED | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Congestive heart failure (B) AS HD DUE TO, OR AS A CONSEQUENCE OF: (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month years years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | Curiosis of the liver | | years | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| NONE | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| NONE | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6-19-72 19 to 7-30-72 19 that (I) (we) lost saw the deceased alive on 7-30-72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) | |
| Bernard Yukna MD | | 7-30-72 | | BERNARD YUKNA | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 8/3/72 | | Holy Cross Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| AUG 2 1972 | | Audrey Johnston | | Schmunek Funeral Home, Inc. | |
| VS 150-REV. 1/1/68 | | 3331 Brehms Lane | | Baltimore, Md. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

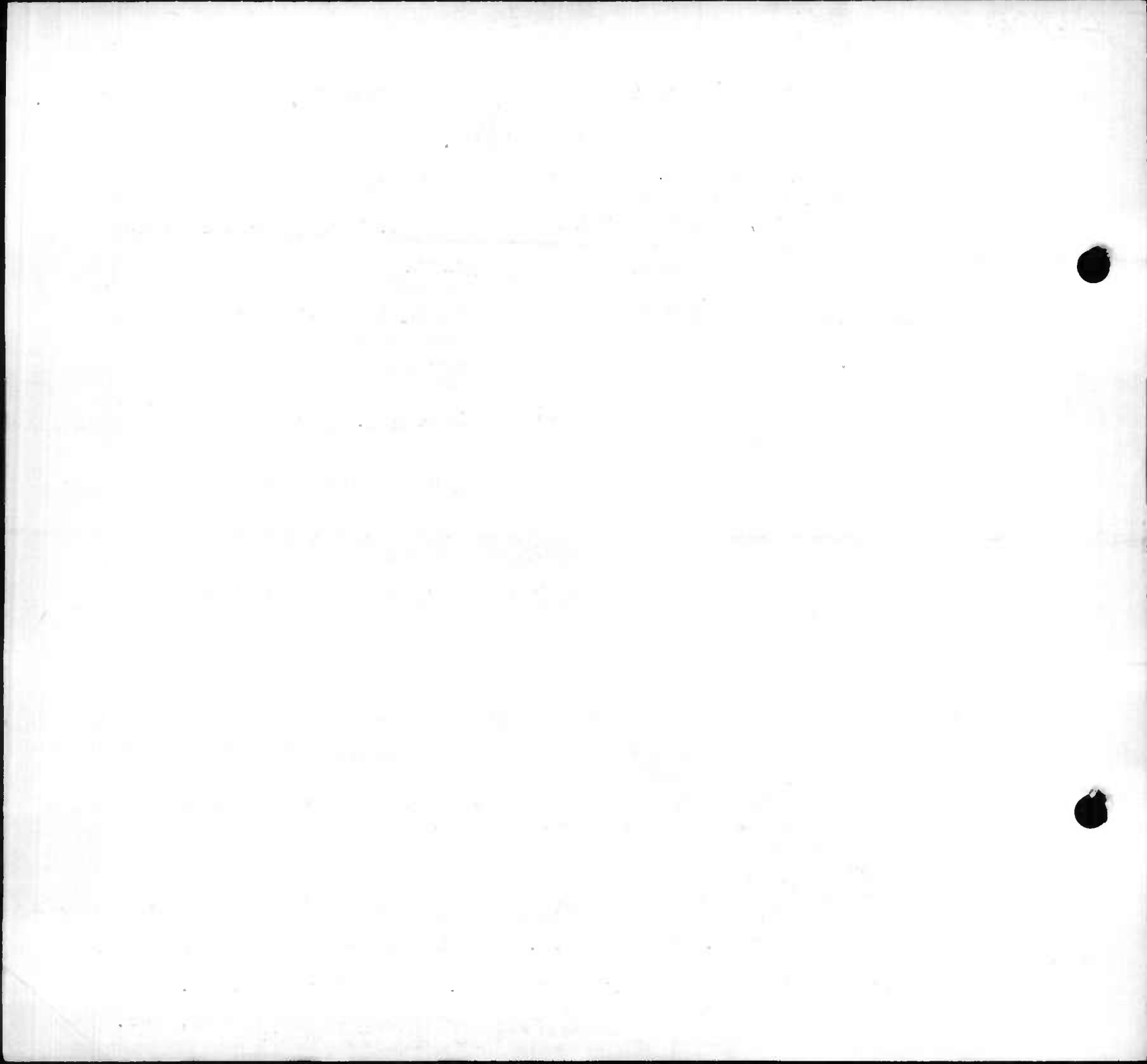
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07305 | |
|---|---------|---|---|--|---|
| 72 07305 CERTIFICATE OF DEATH | | | | | |
| STATE OF MARYLAND-DMH | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Kelly, Elizabeth | | July 30, 1972 3:15 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE 8. COUNTY | | |
| Pleasant Manor Nursing & Convl. Center 4615 Park Heights Avenue Baltimore, Maryland 21215 | | | Baltimore, Maryland 2610 | | |
| | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? |
| | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER | | |
| | | | 3138 McElderly Street | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| Female | White | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 5/29/95 | 477 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Tailoring | | Grief & Co. | | Baltimore, Maryland | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Thomas Kelly | | | Margaret McSherry | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | 212-24-9739A | | Marie D. Simpson, neice, above | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Heart Failure</i> | | | | | |
| (B) <i>Hypertensive Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| <i>Myxedema</i> | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>July 14, 1972</i> to <i>July 20, 1972</i> that (I) (we) last saw the deceased alive on <i>July 20, 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| <i>Humberto V. Centeja M.D.</i> | | | | <i>July 31, 1972</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| HUMBERTO V. CENTEJA M.D. | | | | 1706 GOUCHER BLVD, BALTIMORE, Md 21204 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 8/1/72 | | Baltimore Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| | | | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| AUG 2 1972 | | <i>Andrey K. Kostin</i> | | <i>Richard C. Lawrence</i> | |
| | | | | 3331 Brehms Lane | |

[Faint, mostly illegible text spanning the main body of the page, appearing to be a list or series of entries.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

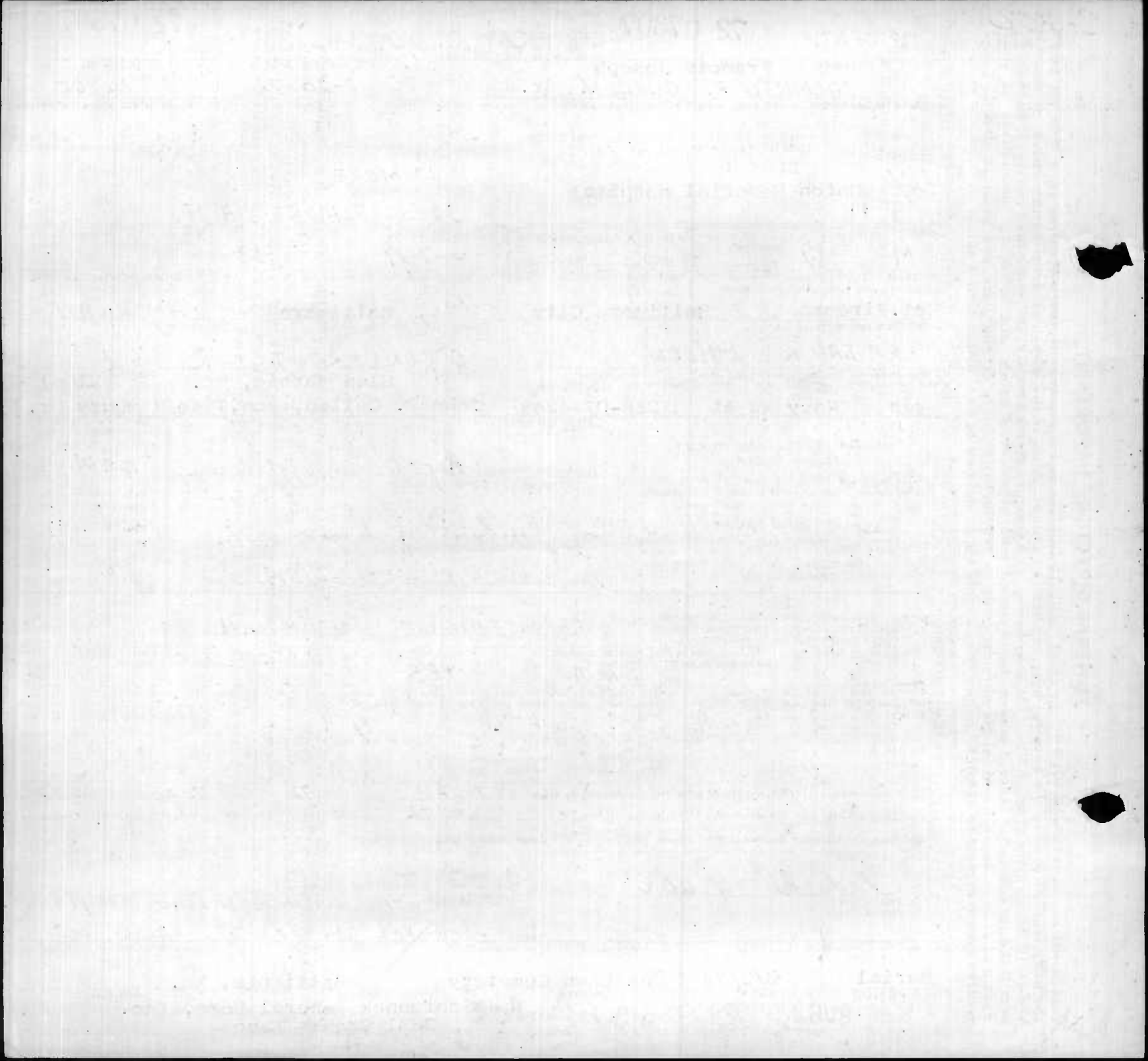
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07306 | |
|--|--|--|--|--|---|
| 72 07306 | | | | 72 07306 | |
| BIRTH NO. | | | | 2 | |
| 1. NAME OF DECEASED (Type or Print) Agnes Adamski | | | 2. DATE AND HOUR OF DEATH July 29, 1972 11 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Good Samaritan Hospital 5601 Loch Raven Boulevard Baltimore, Maryland 21239 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2632 | | |
| 5. SEX F | | | 6. RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY at home | | 8. DATE OF BIRTH 12-06-00 |
| 11. BIRTHPLACE (State or foreign country) Maryland Baltimore | | | 9. AGE (In years last birthday) 71 | | |
| 12. CITIZEN OF WHAT COUNTRY USA | | | 13. FATHER'S NAME Harry B. Bangs | | |
| 14. MOTHER'S MAIDEN NAME Mary Coyne | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 216 48 3786 | | |
| 17. INFORMANT William H. Adams | | | ADDRESS 21234 2905 Putty Hill Ave | | |
| 18. CAUSE OF DEATH 412.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE congestive heart failure DUE TO, OR AS A CONSEQUENCE OF: (B) Hypertensive arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) cardiovascular disease / diabetes APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 22 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 11 1972 to July 29 1972 that (I) (we) last saw the deceased alive on July 29 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Richard J. Owellen M.D. | | | 23B. DATE SIGNED July 29/1972 | | 23C. PHYSICIAN'S NAME (Type) Richard J. Owellen M.D. |
| 23D. ADDRESS 5601 Loch Raven Boulevard 21239 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/2/72 | | 24C. NAME of CEMETERY or CREMATORY New Cathedral Cem. | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR Andrew H. Hoston | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. | |
| 25D. ADDRESS 3381 Brehms Lane | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|---|--|---|--|
| 72 07307 | | BALTIMORE CITY HEALTH DEPT. | | 72 07307 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | |
| Francis Joseph MICHAEL E. CULLEN Sr. | | 7-30-72 14:05 M. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO | |
| FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER 3205 ELMORE AVE. | | 5. SEX M | | 6. RACE W | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 4-7-19 | | 9. AGE (In years last birthday) 53 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Fireman | | 10B. KIND OF BUSINESS OR INDUSTRY Baltimore City | | 11. BIRTHPLACE (State or foreign country) MD. Baltimore | |
| 12. CITIZEN OF WHAT COUNTRY? AMERICAN | | 13. FATHER'S NAME PATRICK CULLEN | | 14. MOTHER'S MAIDEN NAME O'CONNER, ESTER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes Navy WW I | | 16. SOCIAL SECURITY NO. 218-07-4243 | | 17. INFORMANT Glen Burnie, Md. 21061 | |
| 18. CAUSE OF DEATH 571.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). RENAL FAILURE, PNEUMONIA | | 19. DATE OF OPERATION 2 N.A. | | 20. CONDITION FOR WHICH OPERATION WAS PERFORMED N.A. | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) N.A. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N.A. | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N.A. | |
| 21D. TIME OF INJURY (APPROX.) N.A. | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? N.A. | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-22 to 7-30 19 72 and that (I) (we) last saw the deceased alive on 7-30 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Tadashi Kuba | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) N.A. | | | | 23D. ADDRESS THE UNION MEMORIAL HOSPITAL 33rd. and CALVERT ST. BALMO. MD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/2/72 | | 24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery | |
| 24D. LOCATION Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR Audrey Ingham | |
| 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. | | 25D. ADDRESS 3331 Brehms Lane | | 25E. DATE 7-28-72 | |



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72 07308 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND-DEMH

REG. NO.

72 07308

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) JOSEPH LONG | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 30 1972 7:45p M. | |
| 6. SEX male | | 7. RACE white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Glen Burnie | |
| 9. DATE OF BIRTH April 8, 1948 | | 10. AGE (In years last birthday) 24 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Philadelphia, Pa. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Joseph Long | | 14. MOTHER'S MAIDEN NAME Dorothy Hibbs | |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman | | 16. KIND OF BUSINESS OR INDUSTRY C&P Telephone Co. | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes Vietnam Conflict | | 18. SOCIAL SECURITY NO. 150-34-5022 | |
| 19. CAUSE OF DEATH E 955 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Shotgun wound of head ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | 20. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 21. DATE OF OPERATION 0 | | 22. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 23. AUTOPSY? (Yes or No) no | | | |
| 24. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING | | 25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | |
| 26. WHERE DID INJURY OCCUR? 504 Balto. & Annapolis Blvd. | | 27. HOW DID INJURY OCCUR? Shot self. | |
| 28. TIME OF INJURY (APPROX.) 7-30-72 5:30 pm | | 29. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 30. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| 31. ACTUAL SIGNATURE EXAMINER'S NAME (Type) Marvin S. Platt, M.D. | | 32. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 33. DATE SIGNED 7-31-72 | | | |
| 34. BURIAL CREMATION, REMOVAL (Specify) Burial | | 35. DATE 8/3/72 | |
| 36. NAME OF CEMETERY or CREMATORY Glen Burnie Haven Mem. Park | | 37. LOCATION (City, town, or county) (State) Glen Burnie, Anne Arundel, Maryland | |
| 38. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 39. NAME OF REGISTRAR Audrey H. [Signature] | |
| 40. FUNERAL DIRECTOR Pasadena Maryland 21122 | | 41. ADDRESS Cully Funeral Home Mountain & Lock Neck Rd. | |

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72 07309

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

72 07309

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SHENK, IVA BLANCHE

2. DATE AND HOUR OF DEATH

JULY 29, 1972 11:25 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)40 ST AGNES HOSPITAL
CATON & WILKENS AVENUES
BALTIMORE, MARYLAND 212294. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

21223 2582

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1010 WILINGTON AVENUE

5. SEX

6. RACE

7. MARRIED ☒ NEVER MARRIED ☐

8. DATE OF BIRTH

9. AGE (In years
last birthday)

If Under 1 Yr.

If Under 24 Hrs.

FEMALE CAUCASIAN

WIDOWED ☐ DIVORCED ☐

04/18/02

70

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

CLARK BLOSSER

14. MOTHER'S MAIDEN NAME

BETTE CROMNER

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

219-40-9992

17. INFORMANT BALTO MD 21229

ADDRESS

ST AGNES' RECORDS CATON & WILKENS AVES

18. 4/10/9 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Acute M.I.?

minutes.

(B) DUE TO, OR AS A CONSEQUENCE OF:

A.S. CVD + atherosclerosis

years

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Azotaemia.

+ 7 days.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If In Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ☒ (this hospital) attended the deceased from JULY 9 19 72 to JULY 29 19 72.
that ☒ (we) last saw the deceased alive on JULY 29 19 72 and that in ☒ (our) opinion death occurred on the date
and hour and from the causes stated above. ☒ (We) (did) ☒ not view the body after death.

23A. SIGNATURE

J. J. Mol.

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

07 29 72

23C. PHYSICIAN'S
NAME (Type)

J. J. Mol.

23D. ADDRESS

ST. AGNES HOSPITAL

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/1/1972

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 2 1972

25B. NAME OF REGISTRAR

Sidney H. Heston

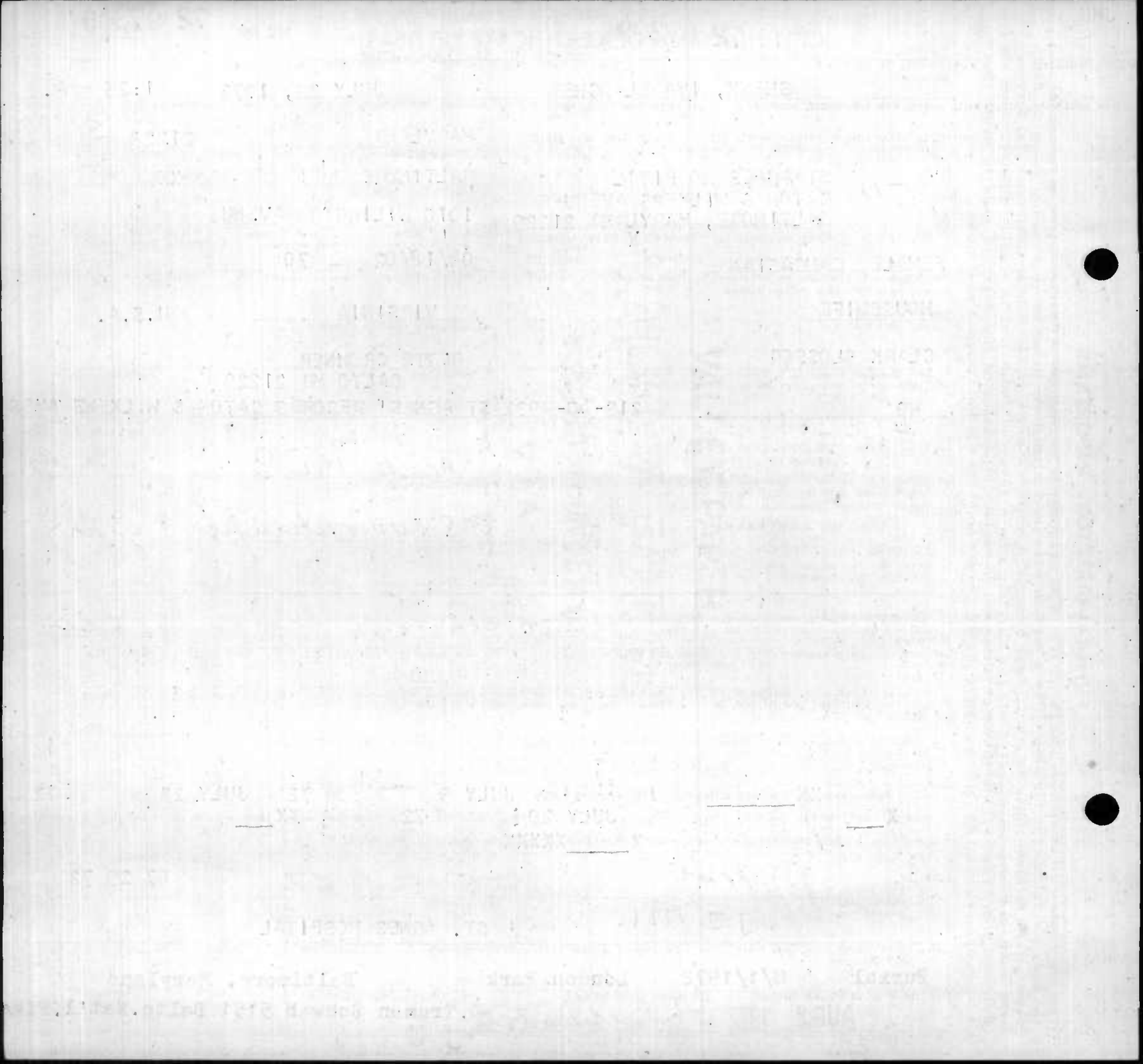
25C. FUNERAL DIRECTOR

F. Truman Schwab 5151 Balto. Nat'l. Pike

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|-------------------|--|---|
| 72 07310 | | 72 07310 | |
| CERTIFICATE OF DEATH | | STATE OF MARYLAND | |
| BIRTH NO. 72 07310 | | REG. NO. 72 07310 | |
| 1. NAME OF DECEASED (Type or Print) WAYMAN, HARRIET | | 2. DATE AND HOUR OF DEATH JULY 24, 1972 6:00 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL WILKENS & CATON AVENUES BALTIMORE, MARYLAND 21229 | | A. STATE MARYLAND B. COUNTY BALTO C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 3 ROBERTS AVENUE | |
| 5. SEX FEMALE | 6. RACE WXX NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 03 15 16 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER | | 9. AGE (In years last birthday) 56 | 11. BIRTHPLACE (State or foreign country) TENNESSEE |
| 13. FATHER'S NAME WILL LINDSEY | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 14. MOTHER'S MAIDEN NAME Joanna ? | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS BALTIMORE, MD. 21229 ST AGNES RECORDS-WILKENS & CATON AVES. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.2 I CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebrovascular accident - Embolism (B) Hypertensive Cardiovascular disease (C) ... II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from JULY 24 19 72 to JULY 24 19 72, that (X) (we) last saw the deceased alive on JULY 24, 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Nirmala Mallya | | 23B. DATE SIGNED 07 24 72 | |
| 23C. PHYSICIAN'S NAME (Type) NIRMALA MALLYA | | 23D. ADDRESS BALTIMORE, MARYLAND 21229 ST AGNES HOSPITAL-WILKENS & CATON AVES | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-29-72 | |
| 24C. NAME of CEMETERY or CREMATORY Spring Grove | | 24D. LOCATION (City, town, or county) (State) Denton Caroline Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR Lindsey Houston | |
| 25C. FUNERAL DIRECTOR | | 25D. ADDRESS Helen Home - Rt. 2, Belts, Md. | |

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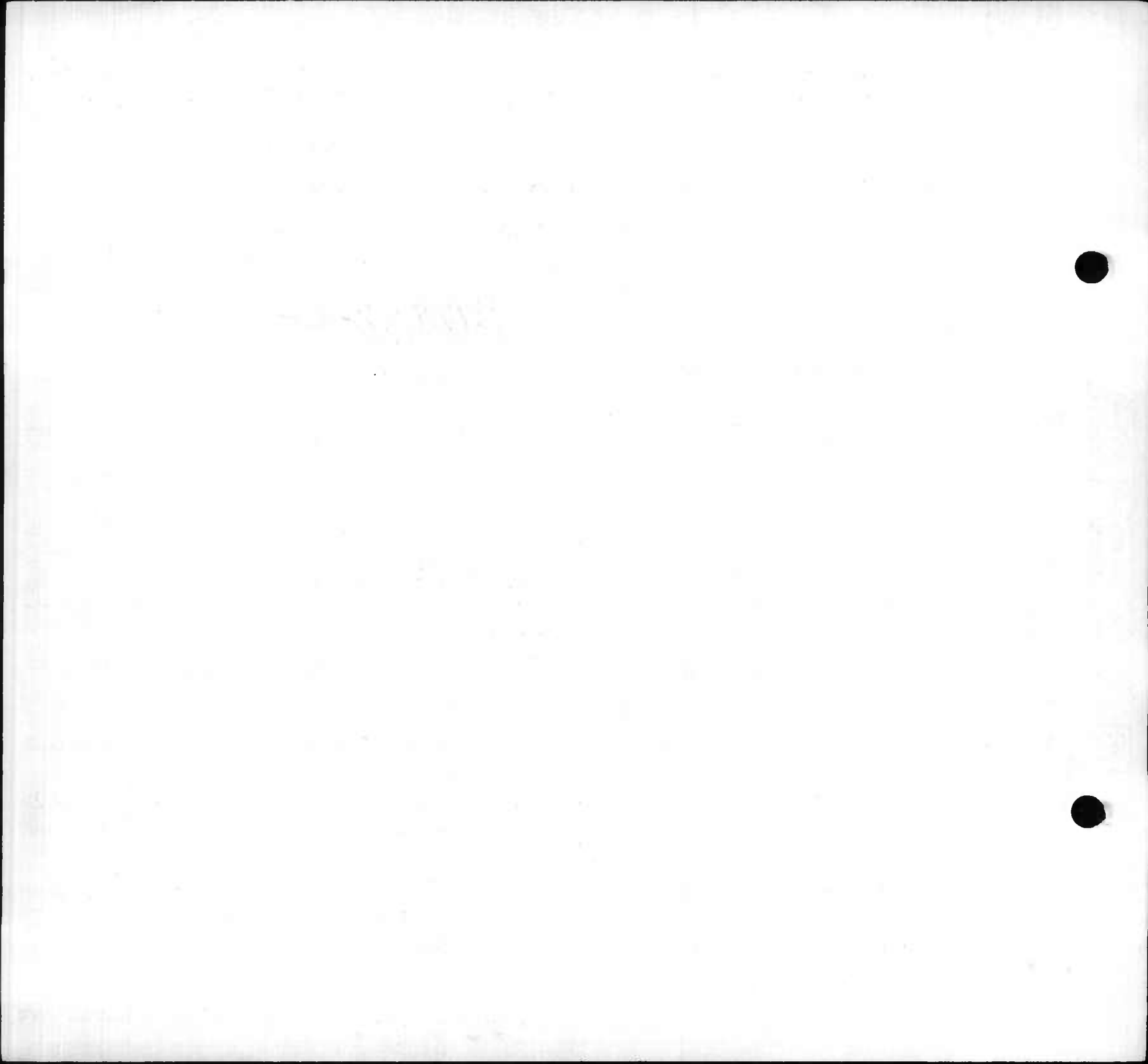
V. J. 78-1-10

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 72 07311 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07311 | |
|---|--|--|--|---|--|
| BIRTH NO. | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | |
| Faust, CORNELIA | | 7-29-72 7P | | M. | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY | | 5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | 6. CITY OR TOWN | |
| MARYLAND 2802 | | GEORGE WASHINGTON NURSING HOME | | BALTIMORE | |
| 7. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 8. E. STREET AND NUMBER | | 9. AGE (In years last birthday) | |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5005 Liberty Heights | | 84 | |
| 10. SEX | | 11. RACE | | 12. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | |
| F | | Negro | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14. KIND OF BUSINESS OR INDUSTRY | | 15. DATE OF BIRTH | |
| Baby's Nurse | | | | 9-10-1888 | |
| 16. FATHER'S NAME | | 17. BIRTHPLACE (State or foreign country) | | 18. CITIZEN OF WHAT COUNTRY? | |
| Allan Faust | | PENNSYLVANIA | | U.S.A. | |
| 19. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 20. SOCIAL SECURITY NO. | | 21. INFORMANT | |
| Unknown | | 218-50-4131 | | MARGARET CHART | |
| 22. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | 23. CAUSE OF DEATH | | 24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 412.1 I | | ARTERIOSCLEROTIC HEART DISEASE | | YRS. | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | YRS. | |
| ANTECEDENT CAUSES | | ARTERIOSCLEROSIS | | YRS | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | Hypertension | |
| II | | Congestive Failure | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | 25. DATE OF OPERATION | | 26. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 0 | | 27. AUTOPSY? (Yes or No) | | 28. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 29. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 30. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 31. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 32. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 33. INJURY OCCURRED | | 34. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 25 Oct 19 71 to 29 July 19 72 that (1) (we) last saw the deceased alive on 28 July 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | 35. SIGNATURE | | 36. DATE SIGNED | |
| Richard Tyson, M.D. | | 7-28-72 | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | |
| 37. PHYSICIAN'S NAME (Type) | | 38. ADDRESS | | 39. DATE | |
| DR. Richard F. Tyson, M.D. | | 936 W. North Avenue Baltimore Maryland 21217 | | 8/2/72 | |
| 40. BURIAL CREMATION, REMOVAL (Specify) | | 41. NAME OF CEMETERY OR CREMATORY | | 42. LOCATION (City, town, or county) (State) | |
| Burial | | New Cathedral | | Baltimore Md | |
| 43. DATE REC'D BY HEALTH DEPT. | | 44. NAME OF REGISTRAR | | 45. FUNERAL DIRECTOR | |
| AUG 2 1972 | | Adolphus H Alstead | | 1206 W North Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-164 72 07312 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 72 07312

BIRTH NO. 72 07312

1. NAME OF DECEASED (Type or Print) SPRUELL, ANDREW 2. DATE AND HOUR OF DEATH 7-28-72 8:29 M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES ☒ NO ☐

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) George Washington Nursing Home E. STREET AND NUMBER 2206 Druid Hill Ave

5. SEX M 6. RACE Black 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH 3-9-1904 9. AGE (in years last birthday) 68 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction 10B. KIND OF BUSINESS OR INDUSTRY Construction 11. BIRTHPLACE (State or foreign country) Wilson, N. C. 12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME Unknown 14. MOTHER'S MAIDEN NAME Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown 16. SOCIAL SECURITY NO. 240-09-9348 17. INFORMANT CHART ADDRESS

18. 436.9 I CAUSE OF DEATH CEREBRAL APoplexy APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROSIS

(B) CVA 1969 DUE TO, OR AS A CONSEQUENCE OF: PSEUDOBULBAR PALSY

(C) RIGHT HEMIPLEGIA

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 0 20A. AUTOPSY? (Yes or No) 0 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 0 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 0 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

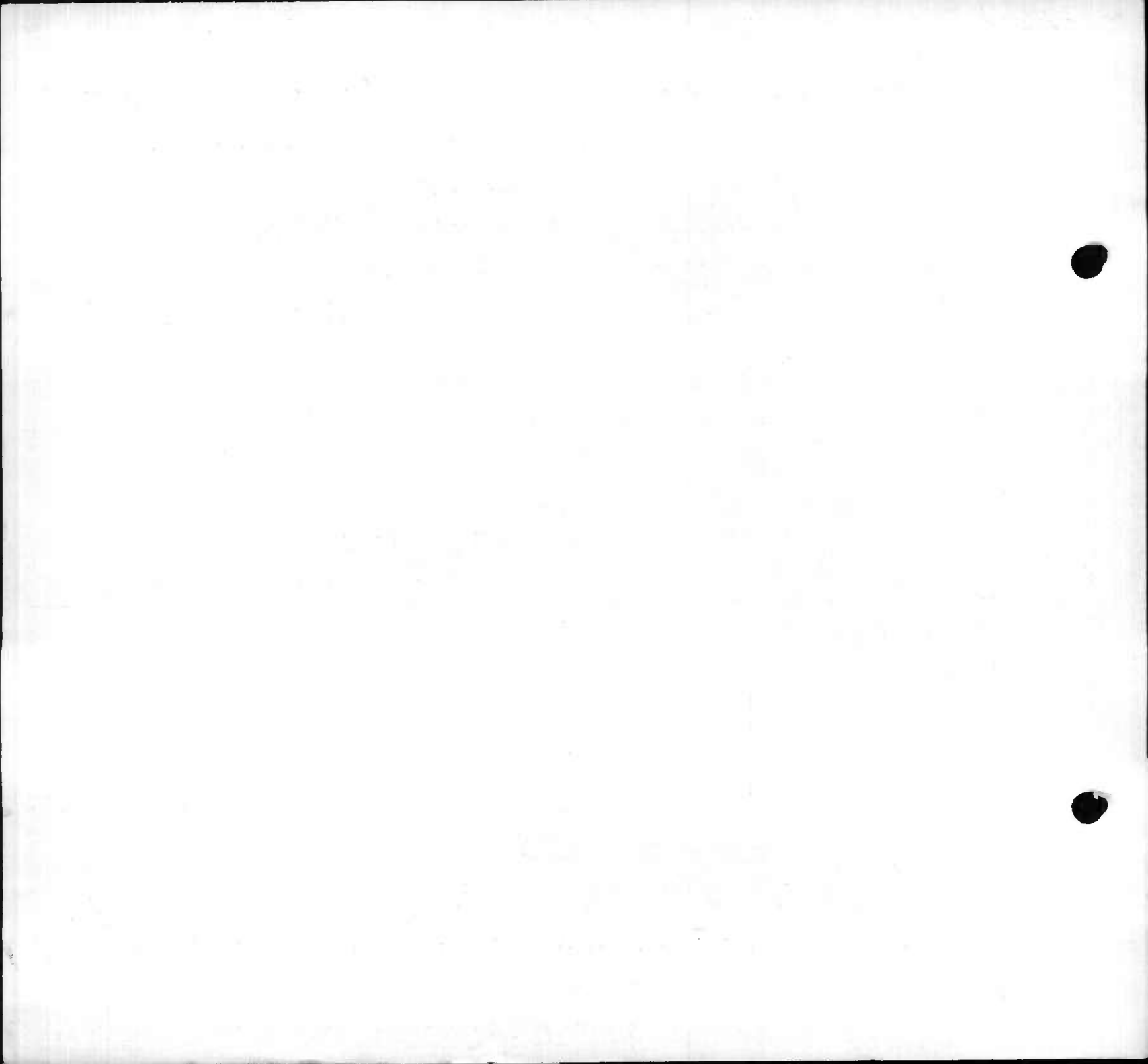
22. I certify that (1) (this hospital) attended the deceased from 28 MAY 19 69 to 28 JULY 19 72 that (1) (we) last saw the deceased alive on 28 JULY 19 72 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE Richard Tyson, M.D. 23B. DATE SIGNED 28 July 72

23C. PHYSICIAN'S NAME (Type) DR. Richard F. Tyson, M.D. 23D. ADDRESS 936 W. North Avenue Baltimore MARYLAND 21217

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial 24B. DATE 8/2/72 24C. NAME of CEMETERY or CREMATORY Maryland National Pk 24D. LOCATION (City, town, or county) (State) Laurel Md

25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 25B. NAME OF REGISTRAR Adolphus Halstead 25C. FUNERAL DIRECTOR Adolphus Halstead ADDRESS 1206 W North Ave



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07313 | | REG. NO. 72 07313 | |
|--|-------------------------|---|--|--|--|---|--|
| BIRTH NO. 72 07313 | | | | CERTIFICATE OF DEATH STATE OF MARYLAND | | | |
| 1. NAME OF DECEASED (Type or Print) Sophia Nemecek | | | | 2. DATE AND HOUR OF DEATH 7/28/72 3:10 p.m. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2505 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL HOSPITAL 3001 S. Hanover St. | | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 1617 ELMTREE ST. | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-12-82 | | 9. AGE (In years last birthday) 90 | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | | 10B. KIND OF BUSINESS OR INDUSTRY Same | | 11. BIRTHPLACE (State or foreign country) CZEK | | 12. CITIZEN OF WHAT COUNTRY? U.S.A |
| 13. FATHER'S NAME UNK. | | | | 14. MOTHER'S MAIDEN NAME UNK. | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT | | ADDRESS | |
| 18. 453X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | (A) IMMEDIATE CAUSE Gangrene Right Leg DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (B) Thrombosis of Inferior Vena Cava DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (C) _____ | | | |
| 19A. DATE OF OPERATION 0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) 1 Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/28/72 19__ to 7/28/72 19__ that (I) (we) last saw the deceased alive on 7/28/72 19__ and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE George Tan, M.D. | | | | 23B. DATE SIGNED 7/31/72 | | 23C. PHYSICIAN'S NAME (Type) George Tan, M.D. | |
| 23D. ADDRESS 4306 Belle Grove Road | | | | 23E. NAME OF REGISTRAR HAHM | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 8-1-72 | | 24C. NAME OF CEMETERY OR CREMATORY HOLY CROSS | | 24D. LOCATION (City, town, or county) (State) Ritchie Hwy BALTO. MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR Sidney Hahn | | 25C. FUNERAL DIRECTOR 4200 PENNINGTON AVE. | | ADDRESS | |

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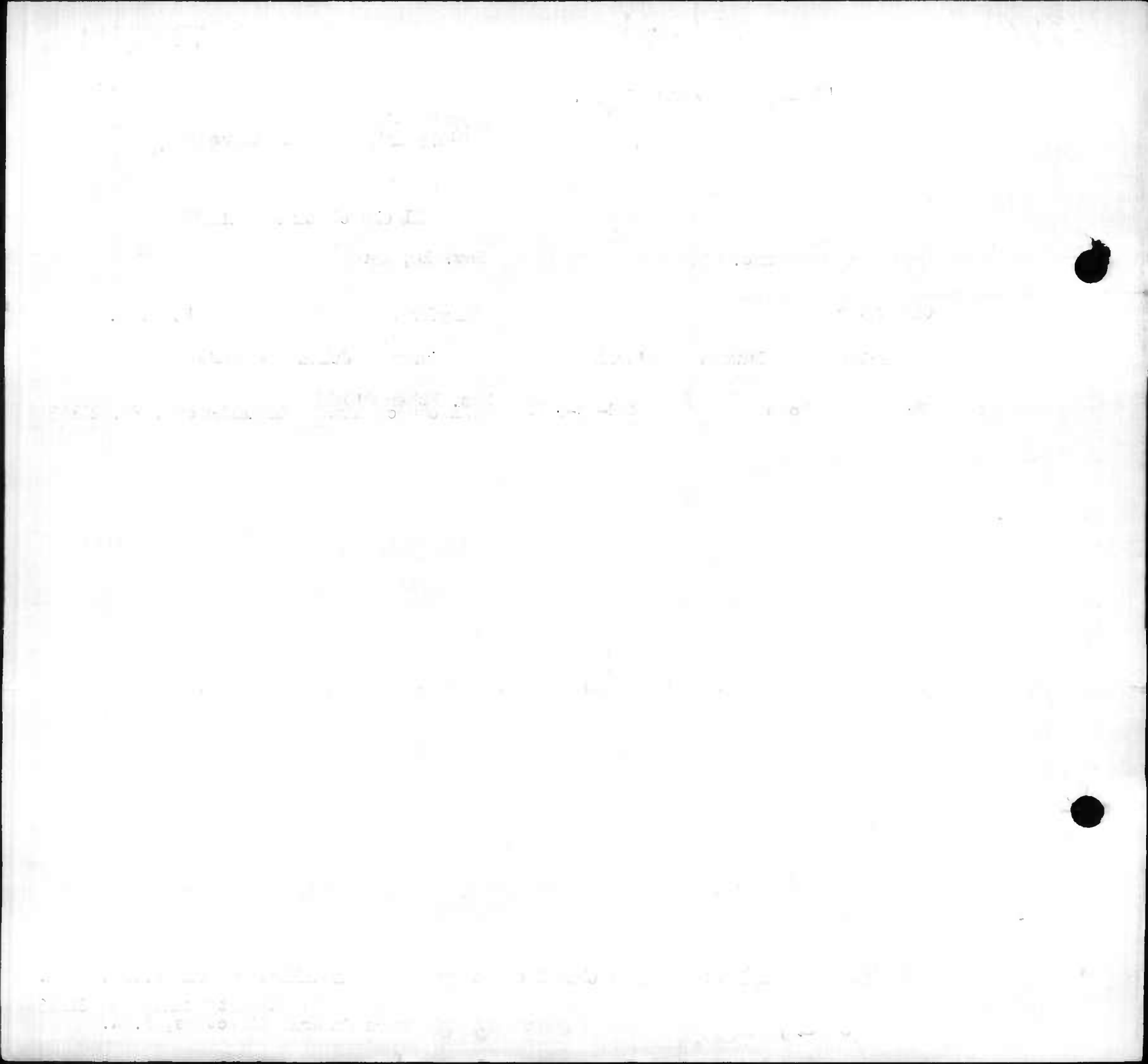
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

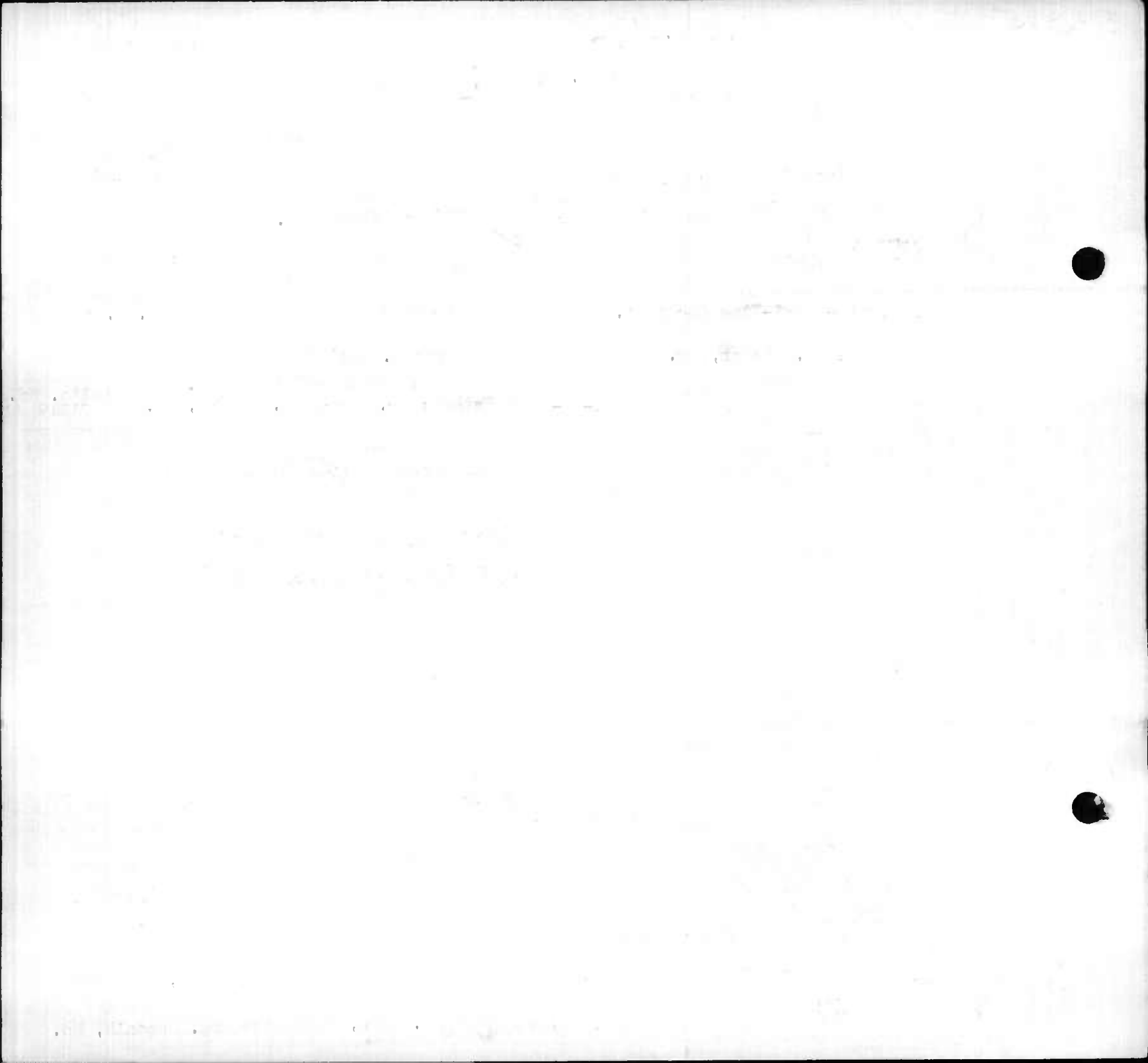
| BIRTH NO. | | 72 07314 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07314 | |
|---|--|--|--|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) | | ODELL, LOUIS D. | | CERTIFICATE OF DEATH | | STATE OF MARYLAND-DHMH | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY | | 2. DATE AND HOUR OF DEATH | |
| 38 UNIVERSITY - HOSPITAL - MARYLAND BALTIMORE | | Maryland Baltimore | | C. CITY OR TOWN RANDALLS TOWN | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| E. STREET AND NUMBER 8611 Church Lane 21133 | | 6. SEX M | | 6. RACE Cauc. | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH Nov. 10, 1908 | | 9. AGE (In years last birthday) 63 | |
| 11. BIRTHPLACE (State or foreign country) Maryland U. S. A. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME Arthur Edward O'Dell | | 14. MOTHER'S MAIDEN NAME Mary Julia (Sutch) | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None | | 16. SOCIAL SECURITY NO. 212-03-5801 | | 17. INFORMANT Mrs. Ether O'Dell 8611 Church Lane | | ADDRESS Randallstown, Md. 21133 | |
| 18. 444.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC - ASYSTOLE (B) <u>AURICULAR FIBRILLATION</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>SYSTEMIC EMBOLISM</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CEREBRO VASCULAR DISEASE | |
| 19A. DATE OF OPERATION JULY 30 - 1972 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED FEMORAL EMBOLISM | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from JULY - 29 1972 to JULY - 30 1972 that (I) (we) lost saw the deceased alive on JULY - 30 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE G. Jag an Mohan 23B. DATE SIGNED July - 30 - 1972 | |
| 23C. PHYSICIAN'S NAME (Type) DR. ATTAR | | 23D. ADDRESS UNIVERSITY HOSPITAL | | 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 8/1/1972 | |
| 24C. NAME OF CEMETERY OR CREMATORY Wards Chapel Cemetery | | 24D. LOCATION (City, town, or county) (State) Randallstown Balto., Co. Md. | | 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR Sidney Ingham | |
| 25C. FUNERAL DIRECTOR Loring Byers | | 728 Liberty Road ADDRESS 21133 | | 25D. FUNERAL DIRECTORS, P. A. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

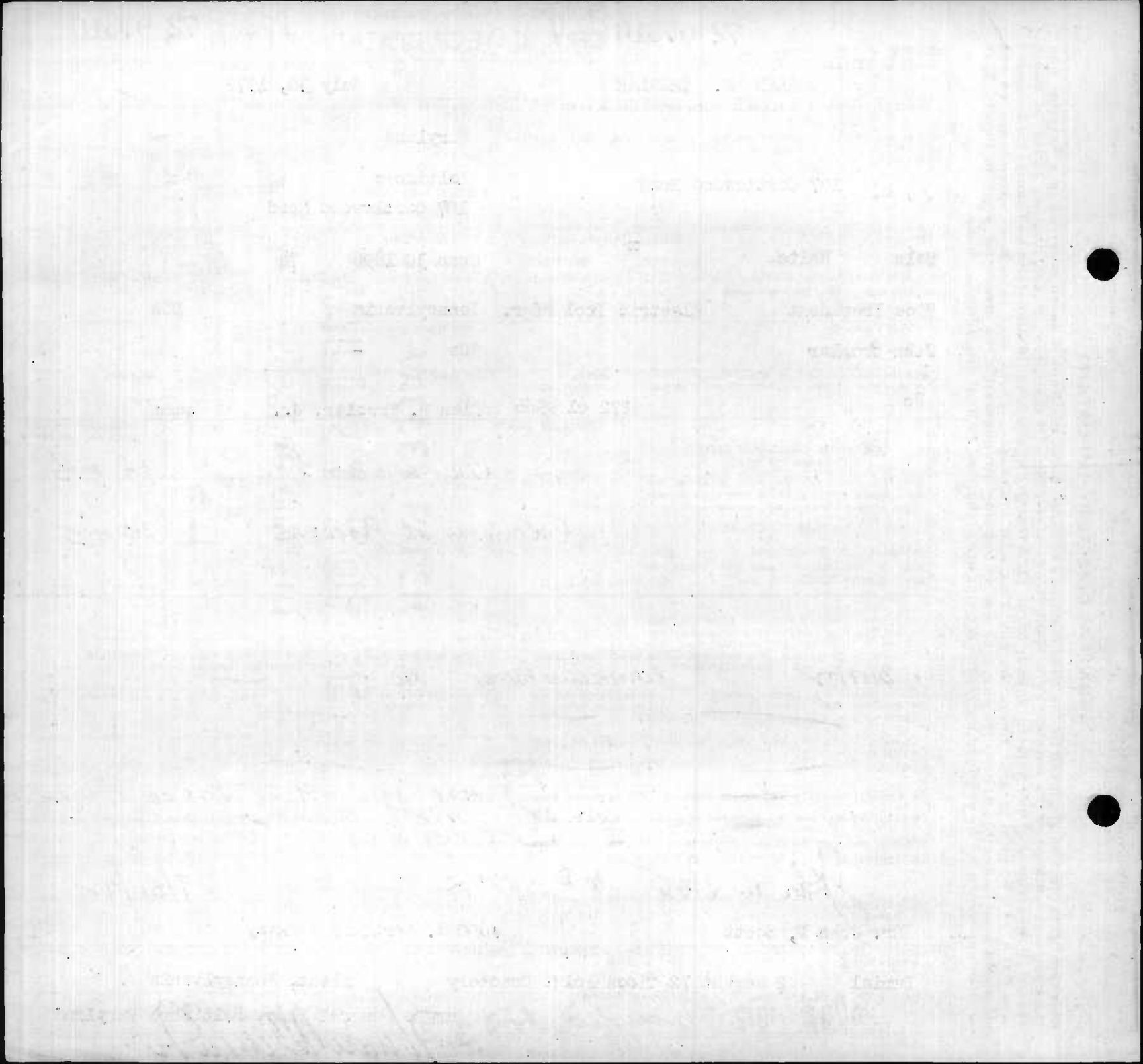
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07315 | | REG. NO. 72 07315 | |
|---|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | |
| STATE OF MARYLAND-DEMH | | | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>Stefan Paul</i> | | Paul T. Stefan | | 2. DATE AND HOUR OF DEATH <i>7/29/72</i> <i>3:50 A</i> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>University of Maryland Hospital</i> <i>University of Maryland Hospital.</i> | | | | A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN <i>Edgemere</i> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX <i>Male</i> 6. RACE <i>White</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH <i>9/29/53</i> | | 9. AGE (in years last birthday) <i>18</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dependent - Part-Time</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Hecht Co.</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 13. FATHER'S NAME <i>George J. Stefan, Sr.</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Anna H. Musinsky</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | | 16. SOCIAL SECURITY NO. <i>220-66-0882</i> | | 17. INFORMANT <i>3002 Salisbury Ave.</i> ADDRESS <i>Balto. Md. 21219</i> <i>Father: Mr. George J. Stefan, Sr.</i> | |
| 18. <i>441.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Dissecting Aortic Aneurysm.</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial Aneurysm.</i> (C) <i>Coarctation of Descend. Aorta</i> | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>7/28</i> 19 <i>72</i> to <i>7/29</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>7/29/72</i> 19 <i>72</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Jose V. Iglesias</i> | | | | DEGREE Attending <input type="checkbox"/> Phys. Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>7/29/72</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Jose V. Iglesias M.D.</i> | | | | 23D. ADDRESS <i>University of Md. Hospital.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>8/1/72</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart of Jesus</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>AUG 2 1972</i> | | | | 25B. NAME OF REGISTRAR <i>Adrienne Weston</i> | | 25C. FUNERAL DIRECTOR <i>John J. Duda</i> ADDRESS <i>7922 Wise Ave. Dundalk, Md.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

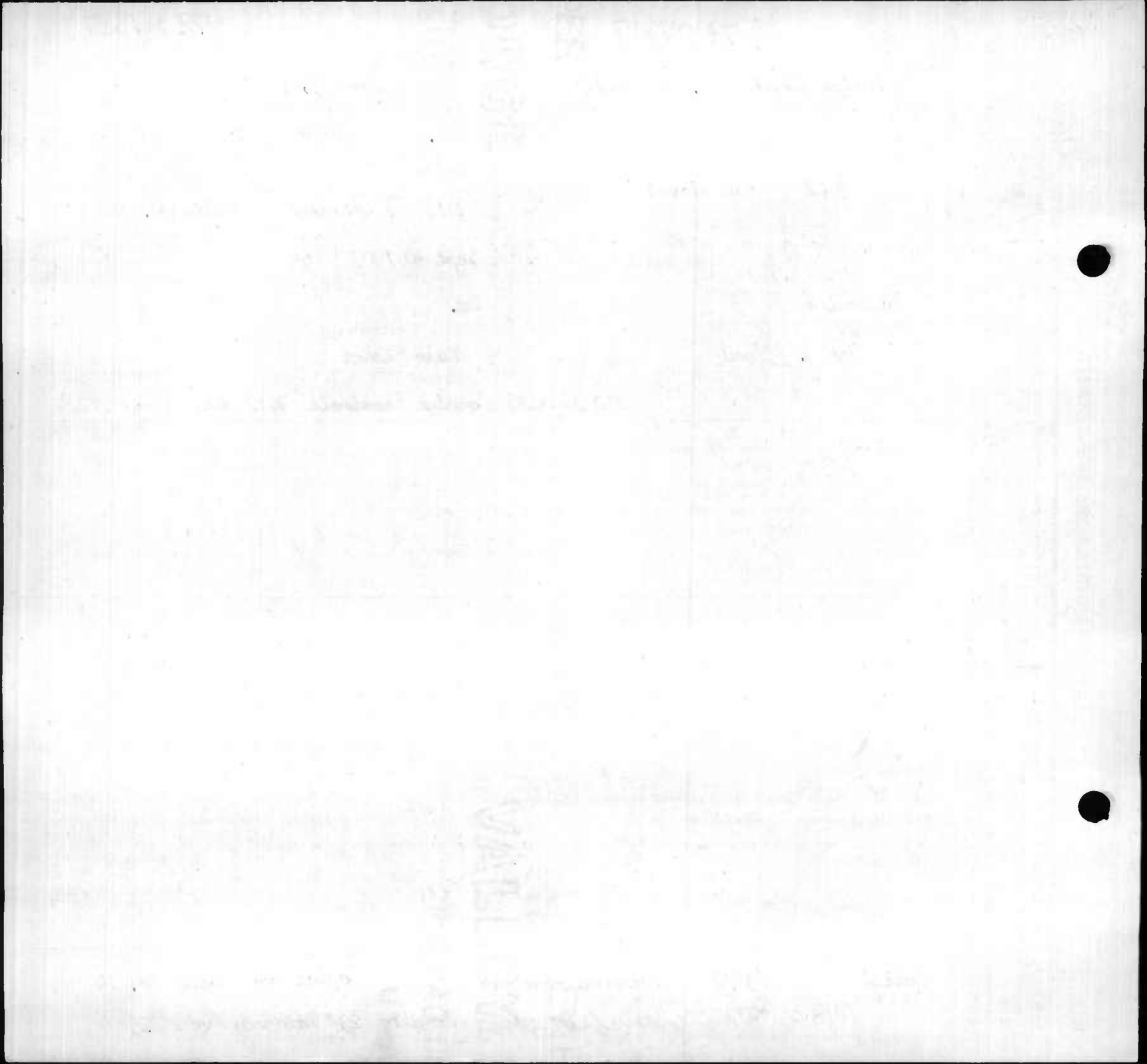
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>72 07316</u> |
|---|-------------------------|--|---|---|
| 72 07316 | | CERTIFICATE OF DEATH STATE OF MARYLAND-DMH | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>GLEN H. TRESLAR</u> | | |
| 2. DATE AND HOUR OF DEATH <u>July 30, 1972</u> | | M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2712</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u> <u>107 Castlewood Road</u> | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER <u>107 Castlewood Road</u> | | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 30 1898</u> | 9. AGE (In years lost birthday) <u>74</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Vice President</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Electric Tool Mfr.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> |
| 13. FATHER'S NAME <u>John Treslar</u> | | 14. MOTHER'S MAIDEN NAME <u>Ada</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>272 01 9566</u> | | 17. INFORMANT <u>Glen H. Treslar, Jr.</u> |
| | | | | ADDRESS <u>same</u> |
| 18. <u>157.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CARCINOMA T0.513</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>CARCINOMA OF PANCREAS</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>14 MOS</u> <u>20 MOS</u> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION <u>0 3/17/72</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>EXPLORATION OF ABDOMEN</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____ | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? _____ |
| 22. I certify that (I) (the hospital) attended the deceased from <u>MAY 1</u> 19 <u>59</u> to <u>JULY 30</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>JULY 28</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <u>John M. Scott</u> M.D. | | 23B. DATE SIGNED <u>7/31/72</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Dr. John M. Scott</u> | | 23D. ADDRESS <u>600 W. Northern Parkway</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>2 August 72</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Tioga Point Cemetery</u> |
| 24D. LOCATION <u>Athens, Pennsylvania</u> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 2 1972</u> | | 25B. NAME OF REGISTRAR <u>Andrew J. [Signature]</u> | | 25C. FUNERAL DIRECTOR <u>Burpee Funeral Home, Baltimore Maryland</u> |
| | | | | ADDRESS <u>Burpee Funeral Home, Baltimore Maryland</u> |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07317 | |
|--|------------------|---|---|--|---|
| 72 07317 | | | | 72 07317 | |
| BIRTH NO. | | | | STATE OF MARYLAND - DEPT. | |
| 1. NAME OF DECEASED (Type or Print) <i>Louise E. Treadwell</i> | | 2. DATE AND HOUR OF DEATH <i>July 31, 1972 11:30 A. M.</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>00 3612 6th Street</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Balto</i> C. CITY OR TOWN <i>Balto</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>3612 6th Street Balto Md. 21225</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Sept 30 1907</i> | 9. AGE (In years lost birthday) <i>64</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Md.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>Ira M. Efford</i> | | 14. MOTHER'S MAIDEN NAME <i>Rose Fisher</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>212 28 0026</i> | | 17. INFORMANT ADDRESS <i>Carolyn Treadwell 3612 6th Street 21225</i> | |
| 18. <i>157.98-250.9</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>Metastatic cancer of the liver</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <i>Congestive heart failure</i> <i>Stroke</i> | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Metastatic cancer of the liver</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Cancer of the pancreas</i> (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Congestive heart failure</i> <i>Stroke</i> | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>no</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>June 29 1971</i> to <i>July 21, 1972</i> , that (I) (we) last saw the deceased alive on <i>July 21, 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Imre Neubauer, M.D., P.A.</i> | | | | 23B. DATE SIGNED <i>Aug 1, 1972</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Imre Neubauer, M.D., P.A.</i> | | 23D. ADDRESS <i>936 Patapsco Ave. Baltimore, Md. 21225</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>8/3/72</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Parkwood Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Taylor Ave Balto Md. 14</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>AUG 2 1972</i> | | | |
| 25B. NAME OF REGISTRAR <i>Andrew Johnson</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>McAlly 237 Patapsco Ave 21225</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07318 | |
|--|-----------|--|---|--|---|
| C-651 72 07318 | | | | CERTIFICATE OF DEATH | |
| STATE OF MARYLAND | | | | DATE AND HOUR OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | DATE AND HOUR OF DEATH | |
| | | CRAMBLITT RUTH NAOMI | | JULY 29, 1972 10:50A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE B. COUNTY | | |
| 40 ST. AGNES HOSPITAL | | | MARYLAND BALTIMORE | | |
| | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? |
| | | | BALTIMORE | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| | | | E. STREET AND NUMBER | | |
| | | | 97 OAKLEE VILLAGE | | 21229 |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months: Days |
| FEMALE | CAUCASIAN | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 09/27/98 | 73 | 10:50A. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| House Wife | | | MARYLAND | | U.S.A. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| WILLIAM KRAFT | | | MARY (SCHMELZ) | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| no | | | | | ST. AGNES HOSPITAL WILKENS & CATON AVES. |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| 412.4 I | | | INTRACTABLE LEFT VENTRICULAR FAILURE | | |
| (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | | (A) IMMEDIATE CAUSE | | |
| ANTECEDENT CAUSES | | | DUE TO, OR AS A CONSEQUENCE OF: | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | ASCVD | | |
| | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II | | | Superimposed pneumonia | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (we, hospital) attended the deceased from JULY 22, 1972 to JULY 29, 1972, that (I) (we) last saw the deceased alive on JULY 29, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Eugenio E. Benitez MD | | | | 07 29 72 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| EUGENIO E. BENITEZ MD | | | | 3350 Wilkens Ave Balto 21229 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | Aug. 1, 1972 | | Loudon Park Cem. | |
| | | | | Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| 1972 07 29 | | G. Truman Schwab | | 5151 Balto. National Pike | |

10:50A

JULY 2, 1972

ST. AGNES HOSPITAL

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ST. AGNES HOSPITAL

ST. AGNES HOSPITAL

ST. AGNES HOSPITAL

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JULY 2, 1972

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-3251

72 07319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 07319

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

M. VIOLA HUTCHINSON

2. DATE AND HOUR OF DEATH

July 27, 1972 1 45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

MARYLAND GENERAL HOSPITAL
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

48

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE B. COUNTY

MD. BALTIMORE CITY 703

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

913 DUNCAN ST.

5. SEX

F

6. RACE

BLACK

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

9-15-06

9. AGE (In years last birthday)

65

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10 12

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

NONE Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA.

13. FATHER'S NAME

Morgan Hutchinson

14. MOTHER'S MAIDEN NAME

Irene West

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO. ?

218-32-6932A

17. INFORMANT

CHART

ADDRESS

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No.

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from July 24, 1972 to July 27, 1972 that (1) (we) last saw the deceased alive on July 27, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Newton W. Rogers MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

7/27/72

23C. PHYSICIAN'S NAME (Type)

Newton W. Rogers

23D. ADDRESS

MARYLAND GENERAL HOSP.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/31/1972

24C. NAME of CEMETERY or CREMATORY

Mt. Zion

24D. LOCATION

Carroll Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 2 1972

25B. NAME OF REGISTRAR

Sidney W. Horton

25C. FUNERAL DIRECTOR

C.M. Waltz, Box 326, Sykesville, Md.

ADDRESS

10-15-57

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72 07320

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 72 07320

CERTIFICATE OF DEATH

STATE OF MARYLAND - DEATH

| | | | | | |
|---|----------------------|---|---------------------------------|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) CHARLES PERKINS | | 2. DATE AND HOUR OF DEATH 7/28/72 1427 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 1602 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY Hospital | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 4940 Eastern Avenue, Baltimore, Md. 21224 | | E. STREET AND NUMBER 1142 N. CALHOUN ST | | 21224 | |
| 5. SEX male | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8/15/82 | 9. AGE (In years last birthday) 89 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY constrctor | | 11. BIRTHPLACE (State or foreign country) South Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 214-01-5994-A | | 17. INFORMANT Records: BCH-4940 Eastern Ave. 21224 Mr. Robert Penny 1506 N. Appleton St | |
| 18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTCEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CAUSE OF DEATH (A) IMMEDIATE CAUSE Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) CARCINOMA of lung DUE TO, OR AS A CONSEQUENCE OF: (C) ATRIAL FIBRILLATION + STROKE | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 days 5 yrs 7 days | | | |
| 19A. DATE OF OPERATION None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/14/72 1972 to 7/28 1972, that (I) (we) last saw the deceased alive on 7/28 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Richard L. Sylvan MD | | 23B. DATE SIGNED 7/28/72 | | 23C. PHYSICIAN'S NAME (Type) Richard L. Sylvan | |
| 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224 | | 23E. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 23F. NAME OF REGISTRAR Sidney W. Heston | |
| 23G. FUNERAL DIRECTOR 1735 Hayfield | | 23H. ADDRESS | | 23I. DATE OF DEATH 7/28/72 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

[Faint, mostly illegible text and markings covering the upper and middle portions of the page. Some faint words like "RECEIVED" and "OFFICE" are visible.]

[Handwritten text at the bottom of the page, appearing to be a signature or set of initials.]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07321

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ELSIE CLARK

2. DATE OF DEATH Known ☐ Month Day Year Hour
Estimated ☐ July 29, 1972 M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

38 University Hospital

3. DATE PRONOUNCED DEAD Month Day Year Hour
7 29 1972 10:30a M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Md. B. COUNTY BALTO. C. CITY OR TOWN Lanham D. INSIDE CITY LIMITS? YES ☐ NO ☐

6. SEX

female

7. RACE

white

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. DATE OF BIRTH

11-26-08

10. AGE (In years, lost birthday)

63 64

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

Spring Grove Hospital

11. BIRTHPLACE (State or foreign country)

Iron Gate, Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Howard Tate

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Home Maker

14B. KIND OF BUSINESS OR INDUSTRY

Own Home

15. MOTHER'S MAIDEN NAME

Elsie Gray Gardner

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

231-70-5678

18. INFORMANT

ADDRESS

James F. Clarke 7209 Sunrise Dr. Lanham, Md.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Pneumonia

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-30-72

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-02-72

24C. NAME of CEMETERY or CREMATORY

National Memorial Park

24D. LOCATION (City, town, or county) (State)

Falls Church, Virginia

25A. DATE REC'D BY HEALTH DEPT.

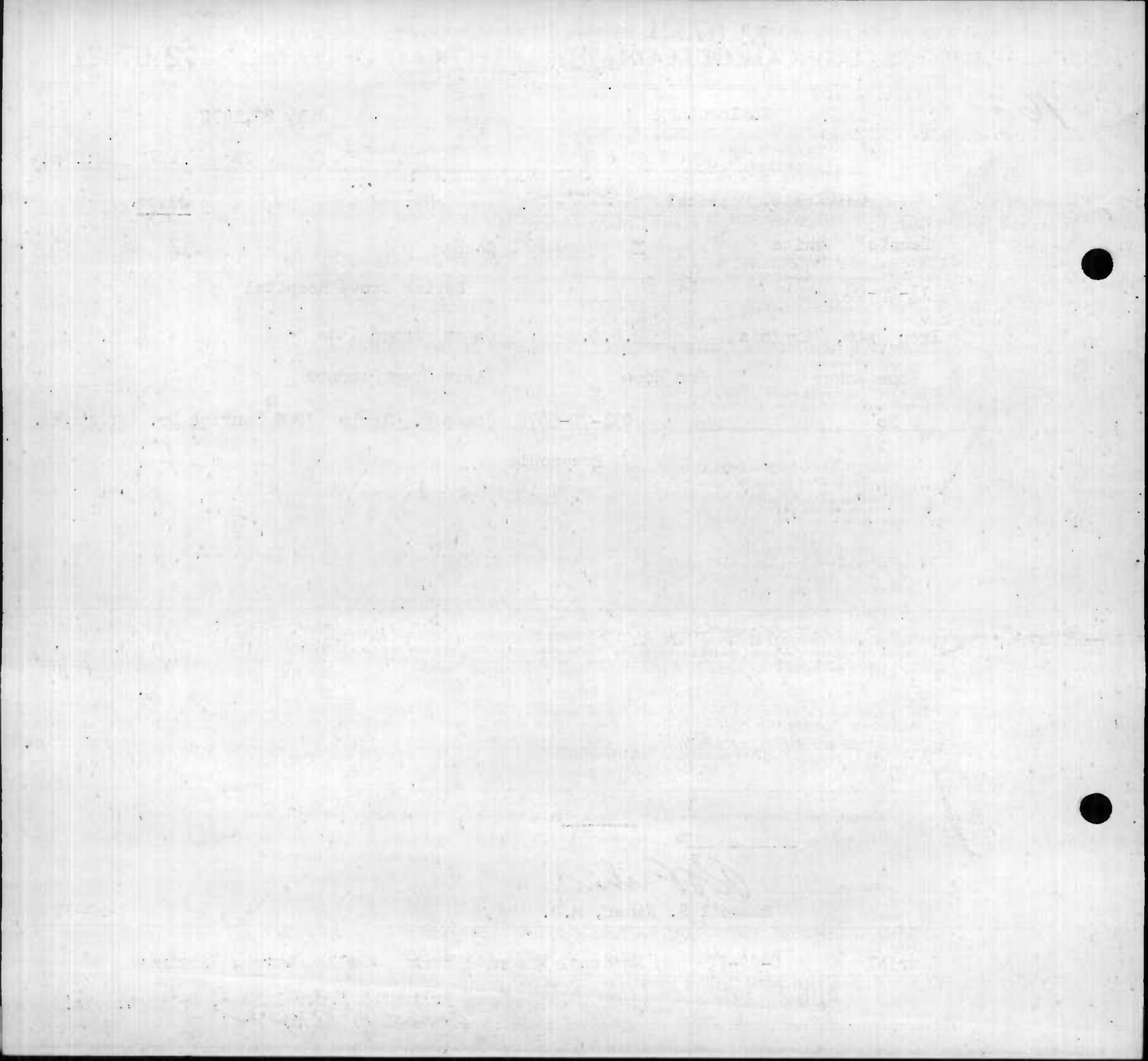
AUG 2 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Arlington Funeral Home, Arlington, Va.

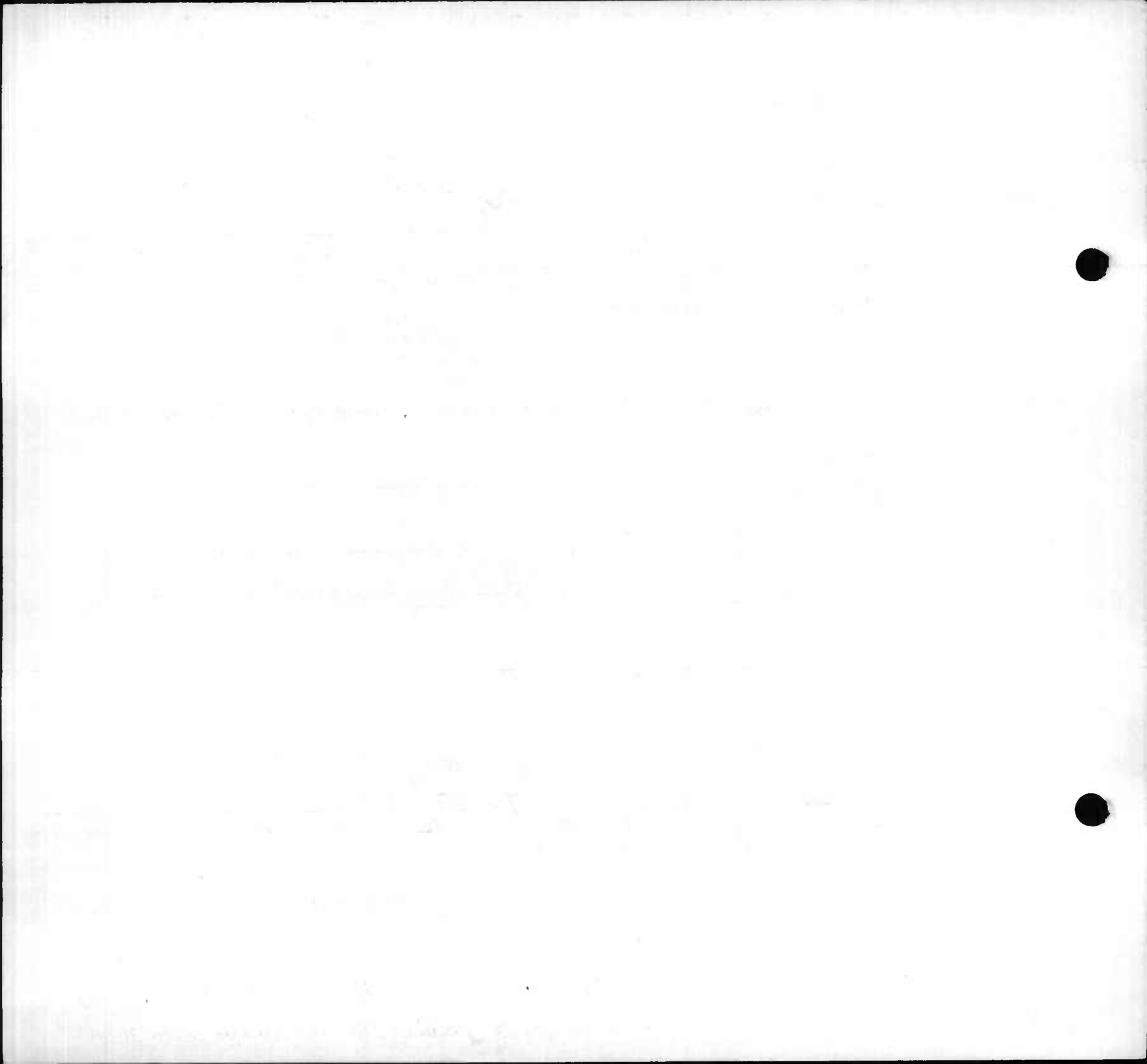


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-600 1

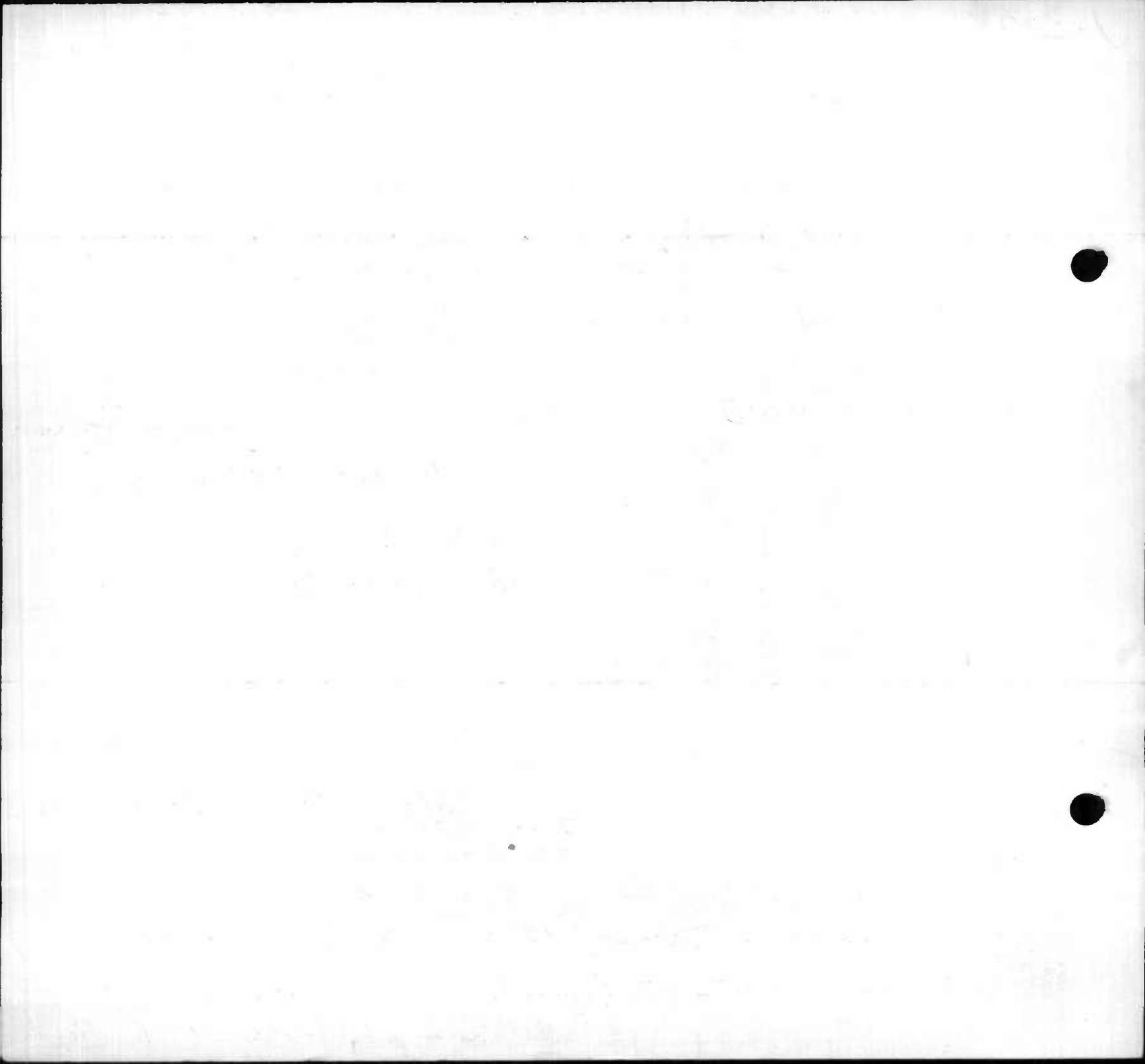
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07322 | |
|---|---------------------|---|--|--|--|
| 72 07322 CERTIFICATE OF DEATH | | | | REG. NO. 72 07322 | |
| 1. NAME OF DECEASED (Type or Print) MOORE JAMES A | | | | 2. DATE AND HOUR OF DEATH 7/30/72 1 7:36 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL HOSPITAL | | | | A. STATE Maryland B. COUNTY 2505 | |
| | | | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 4902 Pennington Ave | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-3-98 | 9. AGE (In years last birthday) 73 | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | 10B. KIND OF BUSINESS OR INDUSTRY Courthouse | | 11. BIRTHPLACE (State or foreign country) Maryland |
| 13. FATHER'S NAME James - A. Moore | | | 14. MOTHER'S MAIDEN NAME Lenora Hancock | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | 16. SOCIAL SECURITY NO. 215 10 5073 | | 17. INFORMANT Myrtle H. Moore |
| | | | ADDRESS 4902 Pennington Ave 21226 | | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| (A) IMMEDIATE CAUSE Cardiogenic shock. DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (B) probably myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (C) Arteriosclerotic cardiovascular disease | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION nil | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED nil | | 20A. AUTOPSY? (Yes or No) nil | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) nil | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) nil | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) nil | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? nil | |
| 22. I certify that (H) (this hospital) attended the deceased from 7-28-1972 to 7-30-1972 that (I) (we) last saw the deceased alive on 7-30-1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE R. Sirithara M.D. | | | | 23B. DATE SIGNED 7/30/72 | |
| 23C. PHYSICIAN'S NAME (Type) R. SIRITHARA M.D. | | | | 23D. ADDRESS South Baltimore General Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/2/72 | | 24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery | |
| | | 24D. LOCATION (City, town, or county) (State) Ritchie Hwy Balto Md. 21225 | | | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR Sidney J. ... | | 25C. FUNERAL DIRECTOR ADDRESS McGully 237 Patapsco Ave Balto 21225 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

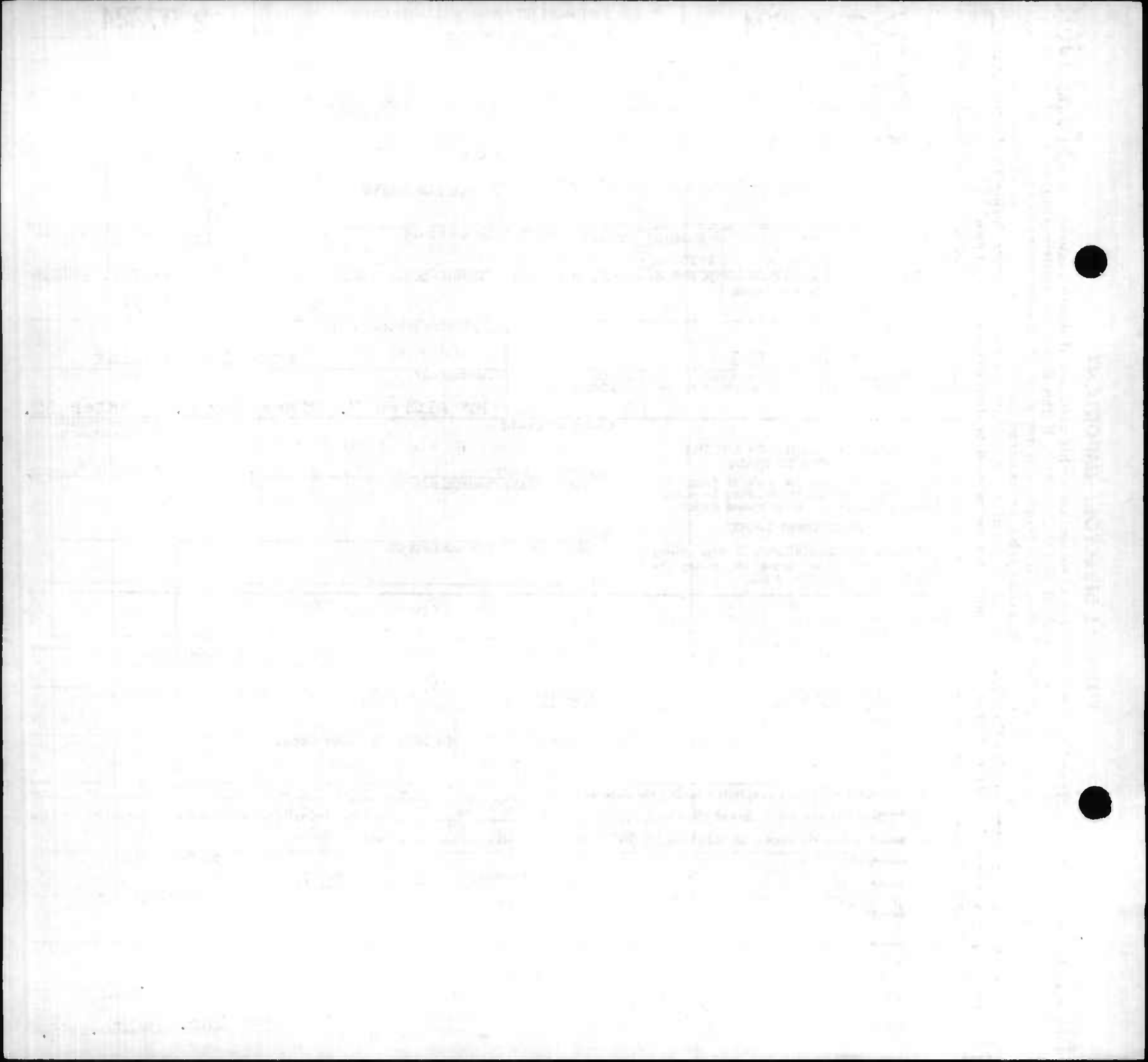
| | | | | | |
|--|--|--|--|---|--|
| 72 07323 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07323 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | |
| James - George | | 7-26-72 11:30 P. M. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD - B. COUNTY 301 | |
| FULL NAME OF HOSPITAL OR INSTITUTION Bolton Hill Nursing Home 1400 John Street | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER 121 No. Broadway | | 5. SEX m 6. RACE B | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 1-9-08 | | 9. AGE (In years last birthday) 64 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed | |
| 11. BIRTHPLACE (State or foreign country) MD | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Unknown | |
| 14. MOTHER'S MAIDEN NAME Unknown | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII | | 16. SOCIAL SECURITY NO. 218-03-874 | |
| 17. INFORMANT Berma Jones - 1410 May Ct Baltimore | | ADDRESS 327-3161 | | 18. CAUSE OF DEATH 250.91 | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yes | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: arteriosclerotic generalized | | yes | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: pulmonary embolism | | | | 1968 | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/4 1970 to 7/26/1972 that (I) (we) last saw the deceased alive on 7/20 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE a. e. m. m. m. | | 23B. DATE SIGNED 7/25/72 | | 23C. PHYSICIAN'S NAME (Type) A. C. H. M. B. C. H. 115 2 E. Red St. Baltimore Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-31-72 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. | |
| 24D. LOCATION Baltimore Md. | | 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR Audrey L. H. H. H. | |
| 25C. FUNERAL DIRECTOR Shirley G. Wilson | | ADDRESS 1000 Brantley Ave. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 72 07324 | | BIRTH DATE | | 72 07324 | |
|--|-------------------------|--|-------------------------------------|---|--|
| BIRTH DATE | | BIRTH DATE | | BIRTH DATE | |
| 1. NAME OF DECEASED (Type or Print) KATHERINE KNOLL | | 2. DATE AND HOUR OF DEATH 1 AUGUST 1972 1 0430 AM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD MARYLAND General Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MD B. COUNTY 2734 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND General Hospital | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER 5440 Belair Rd | | LAYMAN'S M.F. | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-23-82 | 9. AGE (In years last birthday) 89 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Unknown John Uhl | | 14. MOTHER'S MAIDEN NAME UNKNOWN Katherine Schmidt | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 218-12-7596 | | 17. INFORMANT ADDRESS Mr Alfred U. Hines 519 N. Chester ST. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 174X I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH Carcinoma Right Breast, ulcerative, with lymphangitic pulmonary metastases (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 1. Sepsis 2. Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION NONE | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/27 19 72 to 8/1 19 72 that (I) (we) last saw the deceased alive on 8/1 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Victor J. Rogosa, M.D. | | | | 23B. DATE SIGNED 8/1/72 | |
| 23C. PHYSICIAN'S NAME (Type) MARYLAND General Hospital | | 23D. ADDRESS MARYLAND General Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/3/72 | | 24C. NAME of CEMETERY or CREMATORY First Evangelical Church Cem/ Baltimore Md. | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Md. | | 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | | |
| 25B. NAME OF REGISTRY Henry Sander & Sons Inc. Balto. Md. | | 25C. FUNERAL DIRECTOR ADDRESS | | | |



2-400 1

72 07325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 07325

BIRTH NO. STATE OF MARYLAND-DHMH

1. NAME OF DECEASED

(Type or Print)

ROBERT PAUL ZILL JR.

2. DATE AND HOUR OF DEATH

7/31/72 7:40/A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Ugand Hosp

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

702 Tulip Ct Edgewood, Md.

C. CITY OR TOWN

Edgewood

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

702 Tulip Ct

6200

5. SEX

Male

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Feb. 5, 1957

9. AGE (in years
last birthday)

15

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Robert Paul Zill SR.

14. MOTHER'S MAIDEN NAME

Catherine M. Hall

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.
None

17. INFORMANT

Mr Robert Paul Zill SR. Edgewood Md.

18.

207.91

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE Ventilatory Arrest

DUE TO, OR AS A CONSEQUENCE OF:

GI bleed, poss intercranial

(B) bleed and pneumonia in

DUE TO, OR AS A CONSEQUENCE OF:

(C) pt acute leukemia terminal phase

2-3 min

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/31 7:40/A 1972 to 7/31 7:40/A 1972
that (I) (we) last saw the deceased alive on 7/31 7:40/A 1972 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

William G. Ammer MD

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

7/31/72

23C. PHYSICIAN'S
NAME (Type)

23D. ADDRESS

1821 Bolton ST BALTO MD

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/3/72

24C. NAME of CEMETERY or CREMATORY

Ebenezer Church Cemetery Chase Maryland

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 2 1972

25B. NAME OF REGISTRAR

7 2 0 0 0

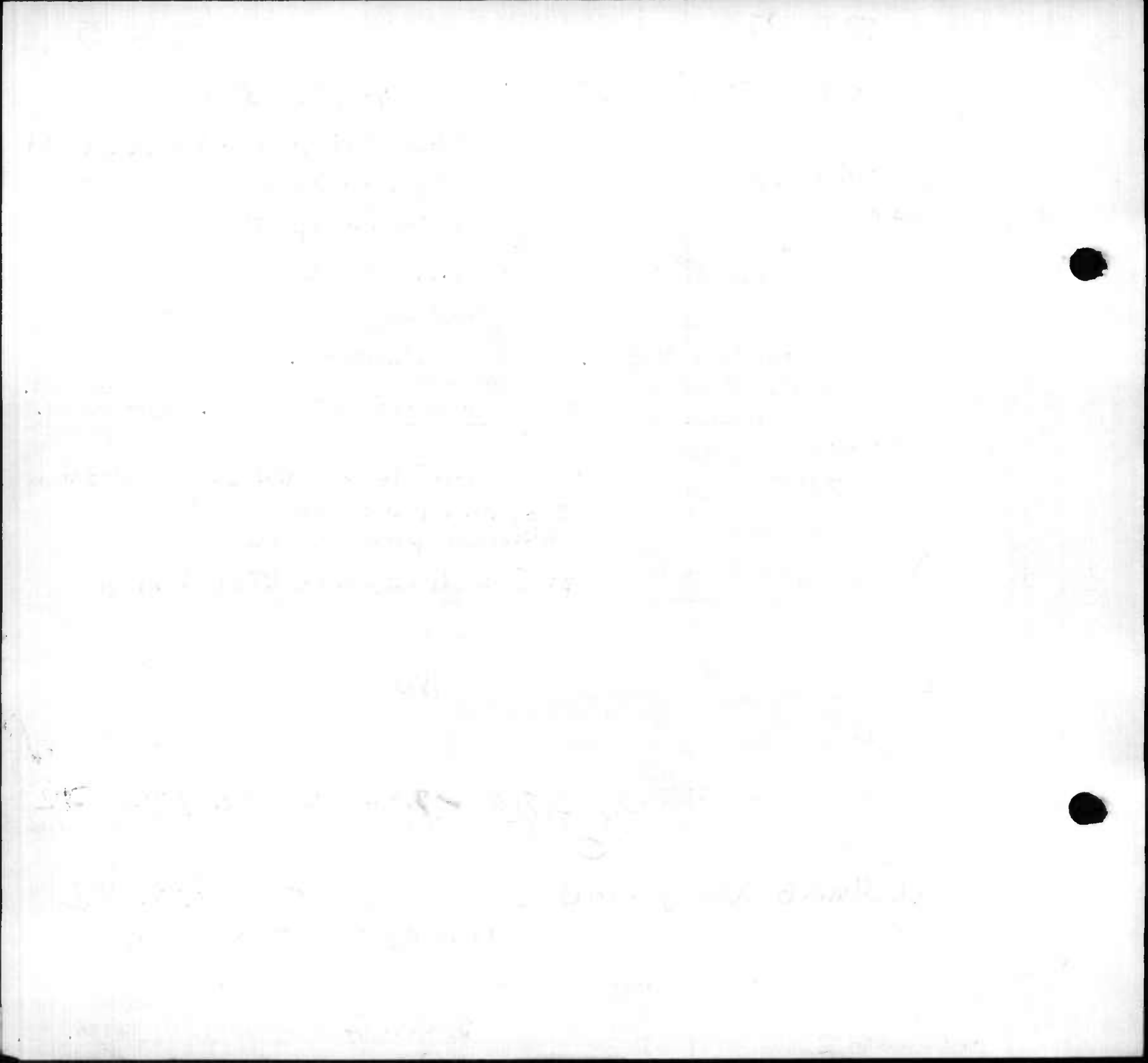
25C. FUNERAL DIRECTOR

HENRY SANDER & SON INC Balto. MD.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



1
A-425
72 07326

STATE OF MARYLAND-DEME

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07326
REG. NO.

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Irene Alexandatos | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 8 1 72 4:40 A.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 Church Home & Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 8 1 72 4:40 A.M. | |
| 6. SEX F | | 7. RACE W | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH 8/18 1940 | | 10. AGE (In years last birthday) 32 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Balto. Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Stephen Jablowski | | 14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 201 | |
| 15. MOTHER'S MAIDEN NAME Genevieve Rogers | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates at service) | | 17. SOCIAL SECURITY NO. 214-38-6444 | |
| 18. INFORMANT Stephen Jablowski | | ADDRESS 245 S. Washington St. | |
| 19. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease | | CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED YES | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. EXAMINER'S NAME (Type) | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 8/5.72 | |
| 24C. NAME of CEMETERY or CREMATORY Most Holy Redeemer | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR Bridgette Johnson | |
| 25C. FUNERAL DIRECTOR Mrs. Charles Sadowski | | ADDRESS 1937 Gough St. Balto Md. | |

8-21-1972 - Completion of cause of death on a pending medical examiner death certificate-
Ronald N. Kornblum, M.D. HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND-DHMH

CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 72 07327

| | | | | | |
|---|-----------|--|--------------------------|--|---|
| BIRTH NO. 72 07327 | | 1. NAME OF DECEASED (Type or Print) JOAN BROWN | | 2. DATE AND HOUR OF DEATH 8/1/72 1:00 PM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GEN. HOSP. 43001 HANOVER ST. BALTIMORE | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYD. B. COUNTY BALTIMORE 2552 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 602 CHERYCREST RD. | | | |
| 5. SEX F | 6. RACE B | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/21/41 | 9. AGE (In years last birthday) 31 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TERRY'S RESTAURANT | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BARY LAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME CYRUS CROSBY (Dec) | | 14. MOTHER'S MAIDEN NAME MARGRET MARDEN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown | | 16. SOCIAL SECURITY NO. 229-52-9231 | | 17. INFORMANT ADDRESS Morris Brown Heathville, Va. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CEREBRA BLEED DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) ANEURYSM (C) DUE TO, OR AS A CONSEQUENCE OF: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At <input type="checkbox"/> Not White <input type="checkbox"/> Work At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/31/72 to 19 to 19, that (I) (we) last saw the deceased alive on 8/1/72 1:10 PM 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE BO' KEEFFE MD. | | 23B. DATE SIGNED 8/1/72 | | 23C. PHYSICIAN'S NAME (Type) BO' KEEFFE | |
| 23D. ADDRESS HOSP. AS IN 3 | | 23E. DEGREE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-6-72 | | 24C. NAME OF CEMETERY OR CREMATORY Church Cem. | |
| 24D. LOCATION (City, town, or county) (State) Heathville, Va. | | 24E. FUNERAL DIRECTOR V. BAILEY | | | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR Sidney H. Hinton | | 25C. ADDRESS 1348 N. Calhoun St. | |

Bureau of Census & Statistics
Washington, D. C.

72 07328

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07328

BIRTH NO.

REG. NO.

| | | | |
|--|------------------|--|--|
| 1. NAME OF DECEASED (Type or Print) ALPHONSO L. HARRIS | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If not in hospital or institution, give street address or location) 39 PROVIDENT HOSPITAL | | 3. DATE PRONOUNCED DEAD Month Day Year Hour July 31, 1972 9:50 P. M. | |
| 6. SEX Male | 7. RACE Negro | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH 8-9-30 | | 10. AGE (In years lost birthday) 42 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Va. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY Rukert Terminal | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 17. SOCIAL SECURITY NO. 219300365 | |
| 18. INFORMANT Elizabeth Harris | | ADDRESS 1655 McKean 1803 Riggs Ave. | |
| 19. E 965X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | CAUSE OF DEATH Gunshot wound of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Tavern | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 7-31-72 7:22 P. m. | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2738 Penna Avenue | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Shot while at a tavern | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Normal causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: <i>Ronald N. Kornblum</i> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. DATE SIGNED 8/1/72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-5-72 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem. | | 24D. LOCATION (City, town, or county) (State) Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG-2 1972 | | 25B. NAME OF REGISTRAR Sidney L. Harrison | |
| 25C. FUNERAL DIRECTOR Kelson F.H. | | ADDRESS 1348 Calhoun Street | |

6-4-30

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| STATE OF MARYLAND - DEMO | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07329 | |
|---|--|---|--|---|--|---|--|
| BIRTH NO. 72 07329 | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) JOHN BOND | | | | 2. DATE AND HOUR OF DEATH 7/30/72 8:35 pm | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1304 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION PROVIDENT HOSPITAL | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2600 Liberty Heights Ave. | | C. CITY OR TOWN Balto. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX m | | 6. RACE N | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12-20-20 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. POST OFFICE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday) 51 | | 11. BIRTHPLACE (State or foreign country) md. | |
| 13. FATHER'S NAME JOHN Bond | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES | | | | 14. MOTHER'S MAIDEN NAME Mary Wilson | | 16. SOCIAL SECURITY NO. 216-16-1561 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 250.91 Congestive Heart Failure | | | | 17. INFORMANT wife | | ADDRESS 2847 Woodbrook Ave Balto. | |
| 19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Diabetic mellitus - Nephrosclerosis - Renal | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION 7 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR | | | |
| 22. I certify that (I) (this hospital) attended the deceased from JUN 30 1972 to JUN 30 1972 that (I) (we) last saw the deceased alive on JUN 30 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Conrado E. Agustin | | | | 23B. DATE SIGNED | | | |
| 23C. PHYSICIAN'S NAME (Type) CONRADO E. AGUSTINI | | | | 23D. ADDRESS | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 8-3-72 | | 24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk. | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE RECD BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR 72000 | | 25C. FUNERAL DIRECTOR V. BAILEY | | ADDRESS 1348 Calhoun St. | |

John Bond

Mary Wilson

1900-1901

md

21

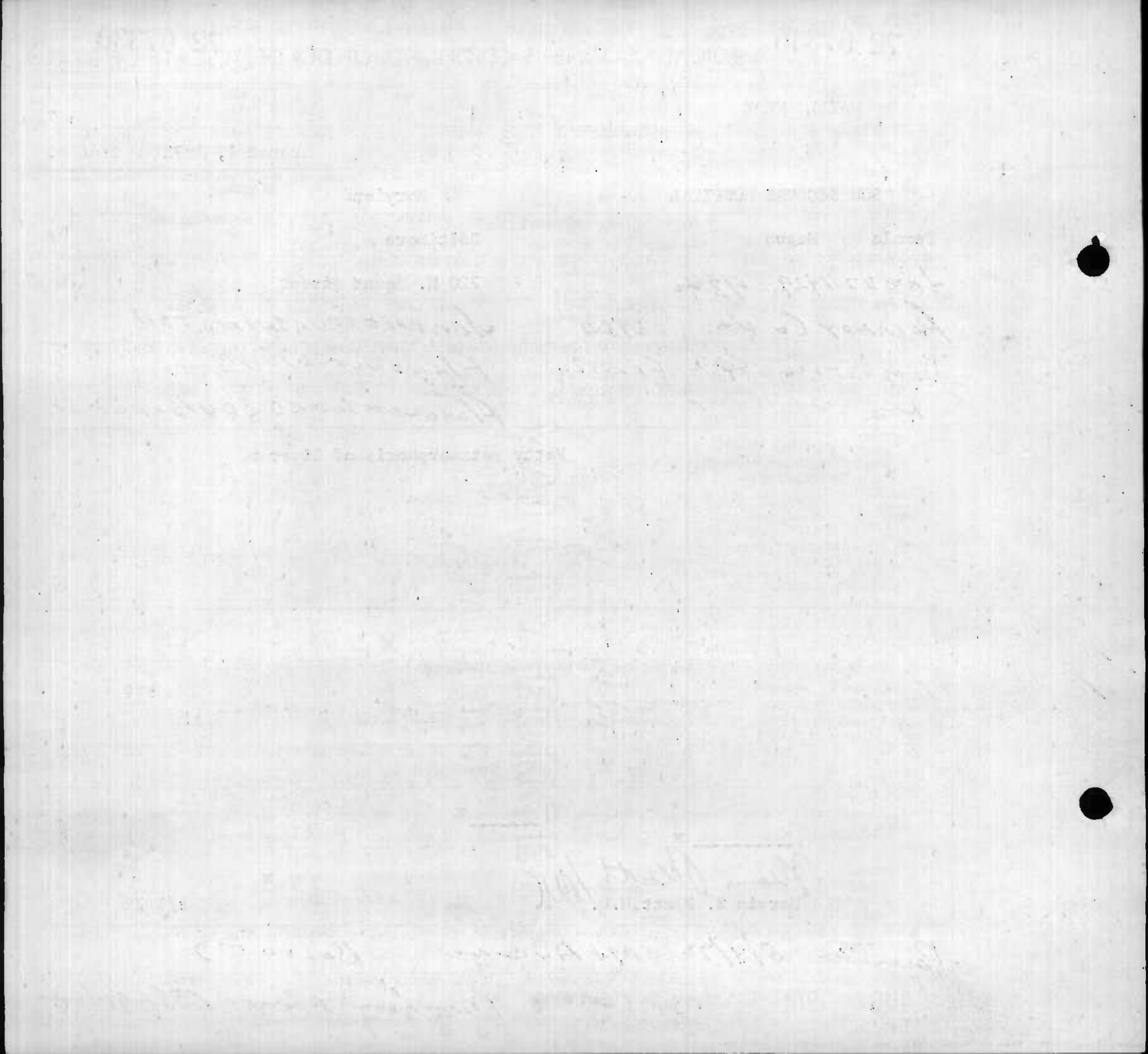
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) MABEL WEBB | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 BON SECOURS HOSPITAL | | 3. DATE PRONOUNCED DEAD Month Day Year August 1, 1972 Hour : 2:48 A. | |
| 6. SEX Female | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 7. RACE Negro | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH Jan 22-1929 | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 10. AGE (In years lost birthday) 43 yr | | E. STREET AND NUMBER 720 N. Mount Street | |
| 11. BIRTHPLACE (State or foreign country) Fairfax Co VA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Jerome Washington | | 14. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Domestic for family | |
| 15. MOTHER'S MAIDEN NAME Florence Webb | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT Florence Webb 304 Bruce St | |

| | | | | | |
|--|--|---|--|--|--|
| 19. 571.81 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | CAUSE OF DEATH Fatty metamorphosis of liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 21. AUTOPSY? (Yes or No) yes |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Marvin S. Platt, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type): Marvin S. Platt, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 8/1/72 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Buried | | 24B. DATE 8/4/72 | | 24C. NAME OF CEMETERY OR CREMATORY Mt Auburn | |
| 24D. LOCATION (City, town, or county) (State) Baltimore | | 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | | |
| 25B. NAME OF REGISTRAR Adrian J. Hooton | | 25C. FUNERAL DIRECTOR Wm. H. Hooton | | ADDRESS 188 N. Mount St | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 72 07331 | | | | BALTIMORE CITY HEALTH DEPT. | | REG. NO. 72 07331 | |
|--|-------------------------|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | STATE OF MARYLAND-DEMH | | | |
| 1. NAME OF DECEASED (Type or Print) Dorothy M. Gegner | | | | 2. DATE AND HOUR OF DEATH 7/31/72 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 90 Hood Nursing Home | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) North Bend & Edmondson Ave. | | A. STATE Ma | | B. COUNTY 2834 | |
| | | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 4803 Coleherne Road | | | |
| 5. SEX female | 6. RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8/9/12 | 9. AGE (In years last birthday) 59 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Milton H. Tapman | | | | 14. MOTHER'S MAIDEN NAME Julia Kavanaugh | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mr. W. Roy Gegner, 4803 Coleherne Road | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 412.417.250.9 ARTERIOSCEROTIC CARDIOVASCULAR DISEASE | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: VASCULAR DISEASE | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 YRS | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: PULMONARY EMPHYSEMA | | 10+ YRS | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes Mellitus | | | | | | 5+ YRS | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1950 to 7/31 19 72 , that (I) (we) last saw the deceased alive on 7/31 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Thomas E. Roach | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 8/1/72 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Thomas E. Roach | | | | 23D. ADDRESS 5550 Baltimore National Pike | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/4/72 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR Andrew W. Poston | | 25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue | | ADDRESS 21228 | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-6201

72 07332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 72 07332

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

James R. Harris

2. DATE AND HOUR OF DEATH

7-29-72

5:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

PROVIDENT HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

2737 N. Rosedale Street

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

11-12-1916

9. AGE (In years last birthday)

55

10. Under 1 Yr. Months Days

11. Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

account- Hilton Court Pharmacy

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William N. Harris

14. MOTHER'S MAIDEN NAME

Geraldine ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

233-14-4971

17. INFORMANT

Mrs. Rebecca Harris 2737 N. Rosedale St

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Carcinoma of the lung with generalized metastasis

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/4 1972 to 7/29 1972 that (I) (we) last saw the deceased alive on 7/29 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.

23A. SIGNATURE

Virginia Fausto-Mercado

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

7/29/72

23C. PHYSICIAN'S NAME (Type)

VIRGINIA F. MERCADO, M.D.

23D. ADDRESS

Provident Hospital Inc.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-3-72

24C. NAME of CEMETERY or CREMATORY

New Town Cemetery

24D. LOCATION

Harrisonburg

(City, town, or county)

(State)

Virginia

25A. DATE REC'D BY HEALTH DEPT.

AUG 2 1972

25B. NAME OF REGISTRAR

Sidney H. [Signature]

25C. FUNERAL DIRECTOR

NUTTER FUNERAL HOME 3035 W. NORTH AVE

3/15/4

3-25-12

3-25-12

✓
Baltimore
MERCANTILE

PROVIDENT HOSPITAL

✓

M. J. VEGAS

1024

General Manager of the Fund
and General Manager of the Fund

1/12

1/12

2/4/12

1/12

✓
4/21/12

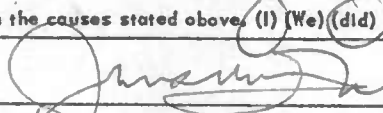
Provident Hospital Inc

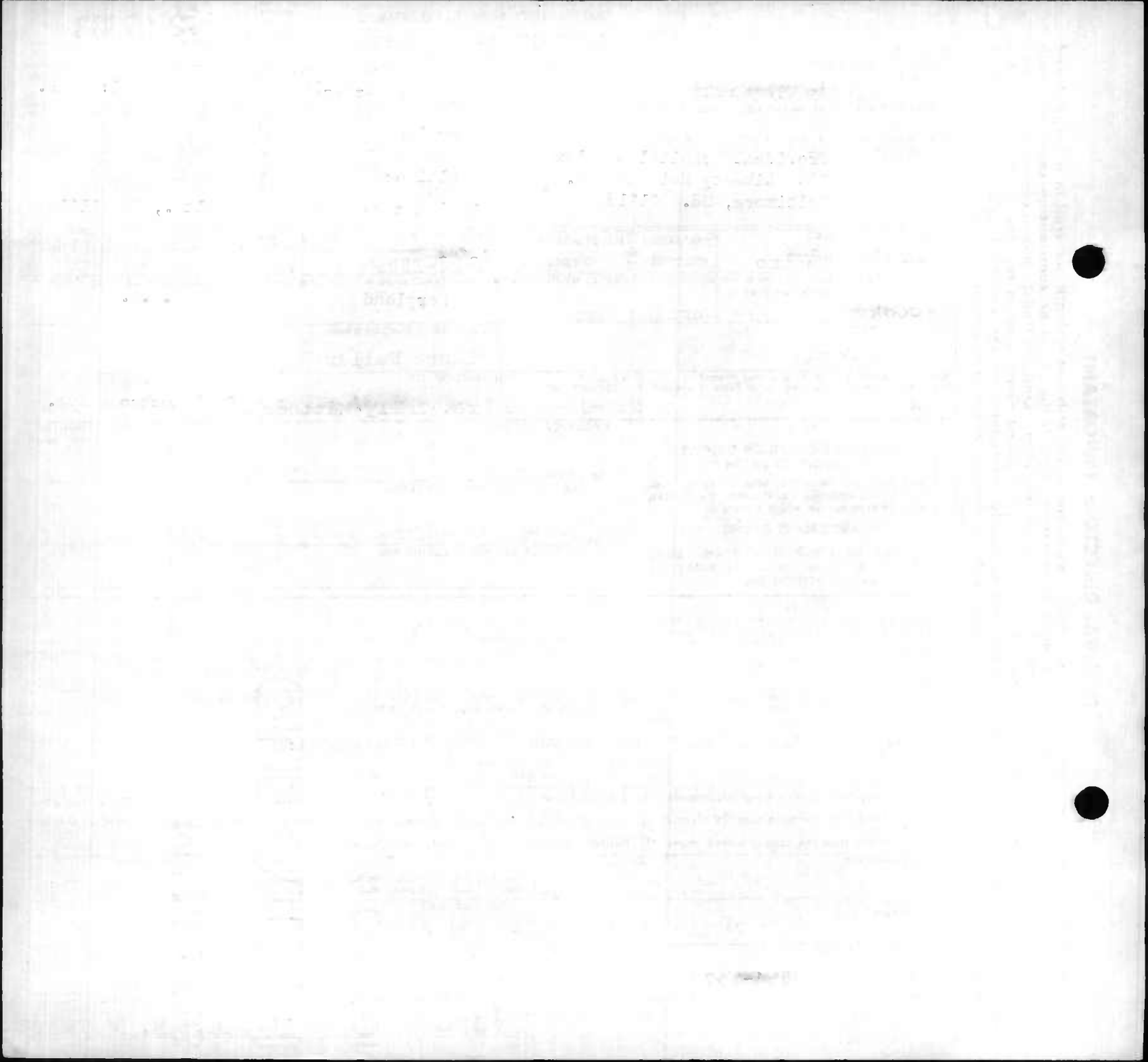
Virginia F. MERCADO, M.D.
Virginia F. MERCADO, M.D.

Individual

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07333 |
|--|-------------------------|--|--------------------------------------|---|
| BIRTH NO. 72 07333 | | CERTIFICATE OF DEATH STATE OF MARYLAND-DEPT | | |
| 1. NAME OF DECEASED (Type or Print) Annie M. Hawkins | | 2. DATE AND HOUR OF DEATH 7-29-72 1:00 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, II institution; residence before admission) A. STATE Maryland B. COUNTY 1512 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital Complex 2600 Liberty Heights Ave. Baltimore, Md. 21215 | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER 2803 Rockrose Ave Balto., Md 21215 | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-24-1901 | 9. AGE (In years last birthday) 71 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cook | | 10B. KIND OF BUSINESS OR INDUSTRY Nursing Home | | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Ross Ford | | |
| 14. MOTHER'S MAIDEN NAME Laura Fuller | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No | | |
| 16. SOCIAL SECURITY NO. 212-32-6053 | | 17. INFORMANT ADDRESS Mrs. Emily Matthews 2803 Rockrose Ave. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 410.01 MYOCARDIAL INFARCTION (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH — | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HYPERTENSIVE C-V DIS | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: ANEMIA | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: — | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 7/8/1972 to 7/29/1972 that (I) (we) last saw the deceased alive on 7/29/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE  | | 23B. DATE SIGNED 7/29/72 | | |
| 23C. PHYSICIAN'S NAME (Type) JOHN S. BRAXTON | | 23D. ADDRESS PROVIDENT HOSP. 2600 LIBERTY HTS. BALTO., MD | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-4-1972 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery |
| 24D. LOCATION Baltimore Maryland | | 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | |
| 25B. NAME OF REGISTRAR A. J. [illegible] | | 25C. FUNERAL DIRECTOR BUTTER FUNERAL HOME 3035 W. NORTH AVE. | | |



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W-536

72 07334

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND - DEPT. OF HEALTH

REG. NO.

72 07334

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) GLENDORIA J. WINDER | | 2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 7 30 1972 8:15 a M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4022½ N. Rogers Ave. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 30 1972 8:15 a M. | |
| 6. SEX female | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 7. RACE negro | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 5-30-1948 | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 10. AGE (In years last birthday) 24 | | E. STREET AND NUMBER 4022½ N. Rogers Ave. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Cornelius Dean | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 14B. KIND OF BUSINESS OR INDUSTRY Home | |
| 15. MOTHER'S MAIDEN NAME Mary Stewart | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 17. SOCIAL SECURITY NO. 219-50-0019 | | 18. INFORMANT Mrs. Mary Jones 3303 Bloomingdale Rd. | |
| 19. E 965X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Gunshot wound of head | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| (B) _____ DUE TO, OR AS A CONSEQUENCE OF: | | (C) _____ | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | |
| 22C. WHERE DID INJURY OCCUR? 4022½ A. N. Rogers Ave. | | 22D. TIME OF INJURY (APPROX.) 7-30-72 | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Shot by husband. | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. DATE SIGNED 7-30-72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-3-1972 | |
| 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park | | 24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR Shirley In... | |
| 25C. FUNERAL DIRECTOR NUFTER FUNERAL HOME 3035 W. NORTH AVE | | ADDRESS | |

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A-352

72 07335 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND - DEM

REG. NO. 72 07335

| | | | | | |
|--|-------------------------|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) Ida Adams | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 7 25 72 | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 25 72 6:10 p. | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1403 | |
| 6. SEX female | 7. RACE Negro | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 6/2/02 | | 10. AGE (In years last birthday) 70 | | E. STREET AND NUMBER 340 Bloom St. 1-G | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Jacob Hill | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 14B. KIND OF BUSINESS OR INDUSTRY Home | | 15. MOTHER'S MAIDEN NAME Bertie Jefferson | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT George E Adams, Sr. | |
| 19. 412.4 | | CAUSE OF DEATH Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) no | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/26/72 | | | | | |
| ACTUAL SIGNATURE Peter Lipkovic, M.D. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/29/72 | | 24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland | | 24E. FUNERAL DIRECTOR Herbert Nutter-3035 W. North Ave | | | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR Sidney Johnston | | 25C. ADDRESS | |

19720003332

STANDARD FORM NO. 64

OFFICE OF THE SECRETARY OF THE ARMY
WASHINGTON, D. C.

TO THE SECRETARY OF THE ARMY

FROM THE SECRETARY OF THE ARMY
SUBJECT: [Illegible]

REFERENCE IS MADE TO [Illegible]

IT IS THE POLICY OF THE ARMY [Illegible]

TO MAINTAIN THE HIGHEST STANDARD [Illegible]

OF EFFICIENCY AND ECONOMY [Illegible]

IN THE OPERATION OF THE ARMY [Illegible]

AND TO SECURE THE BEST [Illegible]

RESULTS POSSIBLE [Illegible]

UNDER THE CIRCUMSTANCES [Illegible]

IT IS RECOMMENDED THAT [Illegible]

THE FOLLOWING ACTION BE TAKEN [Illegible]

AND THAT THE SECRETARY OF THE ARMY [Illegible]

[Handwritten signature]
[Illegible]

1
R-263

72 07336 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07336

| | | | | | |
|--|--|--|--|--|--|
| BIRTH NO. | | STATE OF MARYLAND-DEPT | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) ROBERT RICHARDSON | | | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 730 N. Fulton Ave. | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour M. 7 30 1972 7 p | |
| 6. SEX male | | | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1604 | |
| 7. RACE negro | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH 8-23-1882 | | 10. AGE (In years last birthday) 89 | | E. STREET AND NUMBER 730 N. Fulton Ave. | |
| 11. BIRTHPLACE (State or foreign country) South Carolina | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Rev. John W. Richardson | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer-Proofreader | | 14B. KIND OF BUSINESS OR INDUSTRY Afro-American | | 15. MOTHER'S MAIDEN NAME Susan Bonaparte | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 212-01-7900 | | 18. INFORMANT ADDRESS AMrs. O'Bertha K. Richardson 730 Fulton | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 4124 I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) no | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Marvin S. Platt, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-31-72 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-3-72 | | 24C. NAME of CEMETERY or CREMATORY Family Lot | |
| 24D. LOCATION (City, town, or county) (State) St. Matthews Co., S. C. | | 24E. NAME of REGISTRAR Sidney Inwood | | 24F. FUNERAL DIRECTOR ADDRESS Nutter, Funeral Home 3035 W. North Ave. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07337 |
|---|----------------------|--|-----------------------------------|--|
| 72 07337 | | | | CERTIFICATE OF DEATH |
| STATE OF MARYLAND - DEMO | | | | |
| BIRTH NO. | | DATE AND HOUR OF DEATH 7/26/72 2:45 AM | | |
| 1. NAME OF DECEASED (Type or Print) Arthur D. Spears | | 2. DATE AND HOUR OF DEATH | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE Where deceased lived. If institution: residence before admission! | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Good Samaritan Hospital | | A. STATE Maryland B. COUNTY 402 | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | E. STREET AND NUMBER 660 W. Sanatoga St | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-26-1897 | 9. AGE (In years last birthday) 75 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser | | 10B. KIND OF BUSINESS OR INDUSTRY Cleaners | | 11. BIRTHPLACE (State or foreign country) South Carolina |
| 13. FATHER'S NAME Willie Spears | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-07-5430 | | 17. INFORMANT Mrs. Alice S. Hodnett 702 N. Payson St |
| 18. 199.0 I | | CAUSE OF DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) IMMEDIATE CAUSE G.I. Bleed | | |
| (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | DUE TO, OR AS A CONSEQUENCE OF: | | |
| ANTECEDENT CAUSES | | (B) Metastatic Ca. | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | (C) _____ | | |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) ? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 7/24 19 72 to 7/26 19 72 , that (I) (we) lost saw the deceased alive on 7/26 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE S. Varnell | | | | 23B. DATE SIGNED 7/26/72 |
| 23C. PHYSICIAN'S NAME (Type) _____ | | | | 23D. ADDRESS _____ |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-31-72 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park |
| 24D. LOCATION (City, town, or county) Baltimore Co., Maryland | | (State) _____ | | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR Walter | | 25C. FUNERAL DIRECTOR Walter |
| | | | | ADDRESS 3035 W North |

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1871-1872

March

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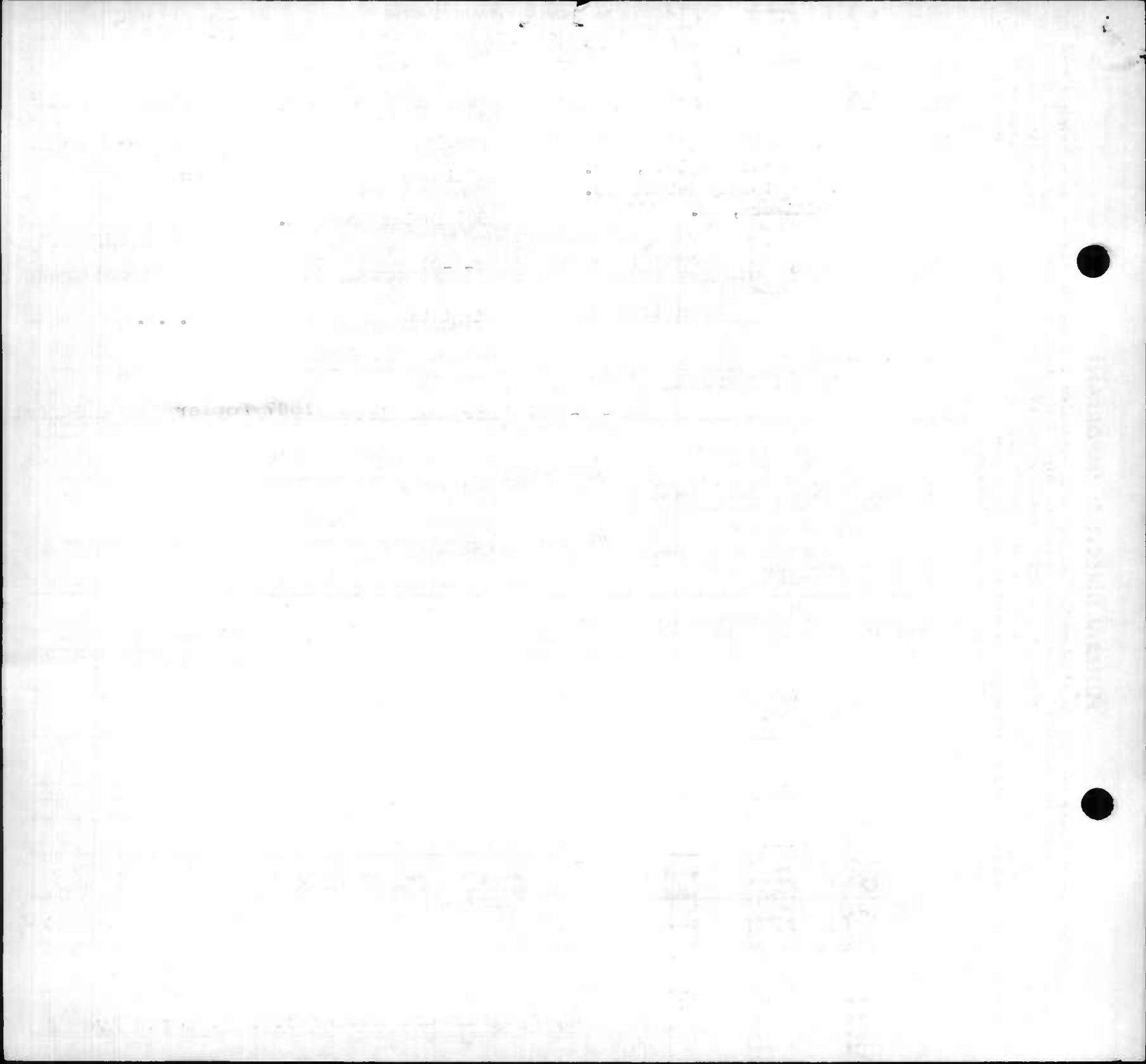
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | |
|---|----------------------|---|---|
| 72 07338 | | REG. NO. 72 07338 | |
| BIRTH NO. | | STATE OF MARYLAND - DEPT. | |
| 1. NAME OF DECEASED (Type or Print) ROSCOE HICKMAN | | 2. DATE AND HOUR OF DEATH 7/23/72 | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1607 | |
| FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. 2600 Liberty Height Ave. Baltimore, Md. 21215 | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1507 Poplar Grove St. | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-5-00 9. AGE (In years last birthday) 71 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 11. BIRTHPLACE (State or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Harvey Hickman | | 14. MOTHER'S MAIDEN NAME Hannah St. John | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220-18-4967A | |
| 17. INFORMANT Margaret Hickman | | ADDRESS 1507 Poplar Grove Street | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 607.51 Nephrotic Syndrome & Uremia | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unknown | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Urinary Tract Infection unknown | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: ASHD & CHF unknown | |
| | | (C) CELLULITIS OF THE PENIS unknown | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Malnutrition & dehydration | | unknown | |
| 19A. DATE OF OPERATION 7-23-72 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED YES | |
| 20A. AUTOPSY (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-19-72 to 7-23-72 that (I) (we) last saw the deceased alive on 7-23-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Aurora C. Tan, M.D. | | 23B. DATE SIGNED 7-23-72 | |
| 23C. PHYSICIAN'S NAME (Type) AURORA C. TAN, M.D. | | 23D. ADDRESS Provident Hospital, Baltimore, Md. 21215 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/27/72 | |
| 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR Herbert Nutter | |
| 25C. FUNERAL DIRECTOR Herbert Nutter | | ADDRESS 3035 W. North Ave | |



1
B-620

72 07339

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND-DEATH

REG. NO.

72 07339

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ELNORE

BROOKS

2. DATE OF DEATH

Known ☐ Estimated ☐

Month 23

Day 72

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR IN INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Lutheran Hosp. (DOA)

3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

7

23

1972

10:50a

M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Md.

B. COUNTY

1503

6. SEX

female

7. RACE

negro

8. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

9. DATE OF BIRTH

4-13-1911

10. AGE (In years last birthday)

61

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

1611 Thomas Ave.

11. BIRTHPLACE (State or foreign country)

Buckingham Co., Va.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Holman

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Sorter

14B. KIND OF BUSINESS OR INDUSTRY

Laundry

15. MOTHER'S MAIDEN NAME

Polly Harris

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

214-24-6958

18. INFORMANT

ADDRESS

Harry Brooks-1611 Thomas Ave

19.

4124

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion

resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL

SIGNATURE

M.D.

EXAMINER'S

NAME (Type)

Marvin S. Platt, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-24-72

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/27/72

24C. NAME of CEMETERY or CREMATORY

Arbutus Memorial Park

24D. LOCATION (City, town, or county) (State)

Baltimore Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 2 1972

25B. NAME OF REGISTRAR

Sidney W. Norton

25C. FUNERAL DIRECTOR

Herbert E. Nutter-3035 W. North Ave

7

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1900

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1900

1900

1900

1900

1900

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1900

72 07340

BALTIMORE CITY HEALTH DEPARTMENT

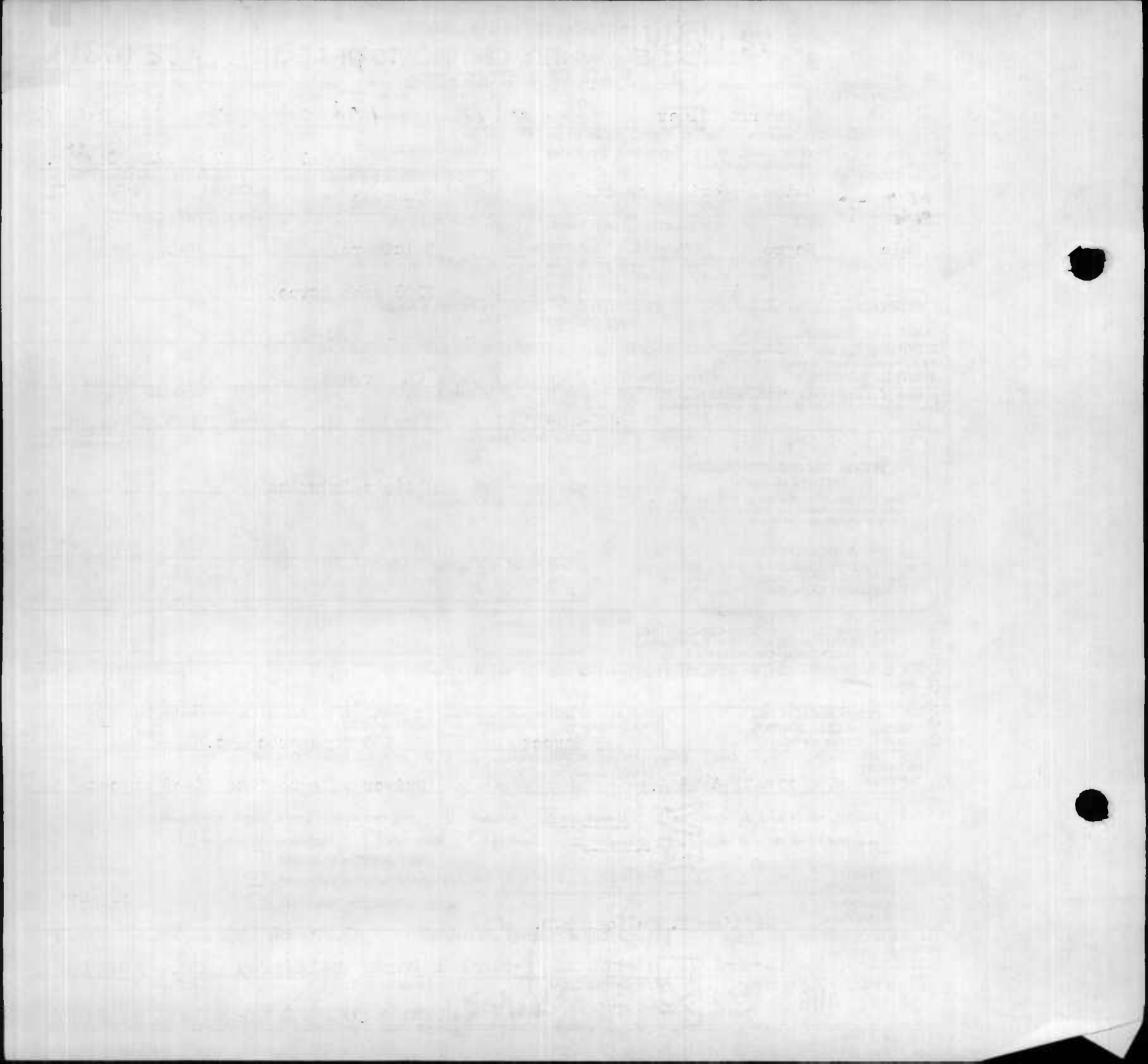
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07340

BIRTH NO.

STATE OF MARYLAND-DEPT

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Robert Palmer | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 7 Day 27 Year 72 Hour 1:40 P.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital | | 3. DATE PRONOUNCED DEAD Month 7 Day 27 Year 72 Hour 1:40 P.M. | |
| 6. SEX Male | | 7. RACE Negro | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 908 | |
| 9. DATE OF BIRTH 5-25-1927 | | 10. AGE (In years lost birthday) 45 | |
| 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Clarence Palmer | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) meat packer | |
| 15. MOTHER'S MAIDEN NAME Ada C. Brown | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 17. SOCIAL SECURITY NO. 245-26-6587 | | 18. INFORMANT Mrs. Evelyn N. Palmer | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) No | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 800 Bonaparte Ave. | | 22D. TIME OF INJURY (APPROX.) 6 27 72 4:25 A.M. | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Driver of auto into fixed object | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) William P. Mulloy, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-28-72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-1-1972 | |
| 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park | | 24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR Audrey H. Weston | |
| 25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME | | ADDRESS 3035 W. NORTH AV | |



W-452

72 07341 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07341

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

MARY E. WILLIAMS

2. DATE

Known ☐

Month

Day

Year

Hour

DEATH

Estimated ☐

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

1212 Whitelock Street

3. DATE

Month

Day

Year

Hour

PRONOUNCED DEAD

July 31, 1972

11:56 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

1303

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

5-8-1878

10. AGE (In years

last birthday)

94

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1212 Whitelock Street

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF

WHAT COUNTRY?

USA

13. FATHER'S NAME

?

?

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

Home

15. MOTHER'S MAIDEN NAME

Henrietta ?

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)
No

17. SOCIAL SECURITY NO.

218-58-5240

18. INFORMANT

ADDRESS

Mrs. Mable Dickerson 1212 Whitelock St.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

Craniocerebral Injuries

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

Hypertensive and arteriosclerotic cardiovascular disease

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1212 Whitelock Street

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

7-26-72

A.M.

22E. INJURY OCCURRED

WHILE AT
WORK ☒NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

Fell at home

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Marvin S. Platt, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/1/72

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8-5-1972

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cemetery

24D. LOCATION (City, town, or county)

Baltimore C

Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 2 1972

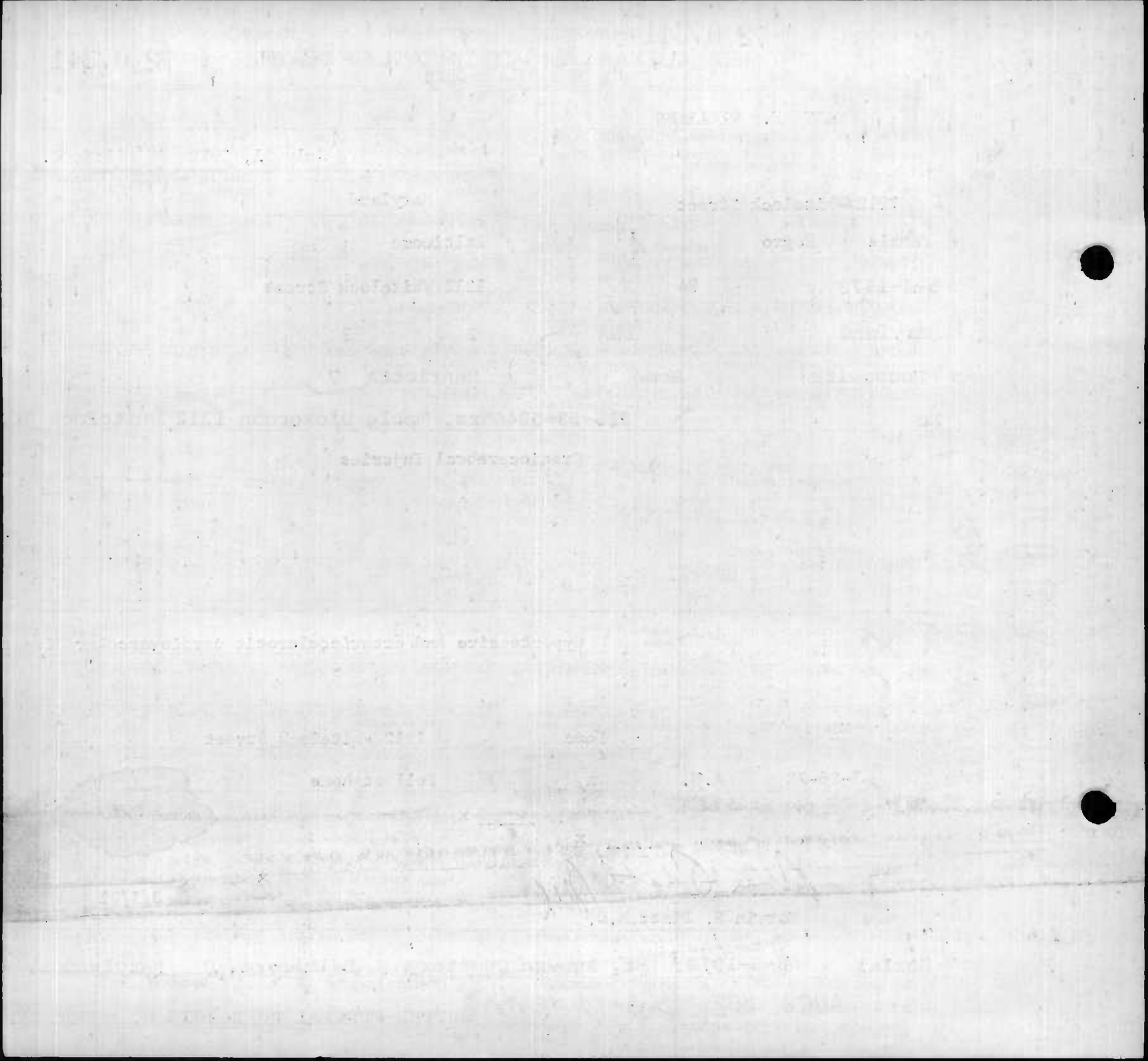
25B. NAME OF REGISTRAR

Audrey H. Weston

25C. FUNERAL DIRECTOR

ADDRESS

BUTTER-FUNERAL HOME 3035 W. NORTH AVE



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 72 07342

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Partee, Levi

2. DATE AND HOUR OF DEATH

July 31, 1972

9:40 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Provident Hospital, Inc.
2600 Liberty Height Ave.
Baltimore, Md. 21215

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

E. STREET AND NUMBER

4410 Wentworth Rd.

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

5. SEX

Male

6. RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

8-27-00

9. AGE (In years last birthday)

71

If Under 1 Yr. Months: Days

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Tow Motor Operator

10B. KIND OF BUSINESS OR INDUSTRY

Ft. Holibird

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Partee

14. MOTHER'S MAIDEN NAME

Esther McKnight

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

220-18-4168

17. INFORMANT

Sophie Hicks 4410 Wentworth Road

ADDRESS

18. 235071

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Malnutrition & dehydration

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

unknown

(B) Diabetic Mellitus by history

DUE TO, OR AS A CONSEQUENCE OF:

Diabetic Mellitus by history

unknown

(C) Previous above knee amputation st.

unknown

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

2 none

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

NO

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At Work ☐

Not White At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7-30 1972 to 7-31 1972 that (I) (we) last saw the deceased alive on 7-31 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Aurora C. Tan, M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

7-31-72

23C. PHYSICIAN'S NAME (Type)

AURORA C. TAN, M.D.

23D. ADDRESS

Provident Hospital, Baltimore, Md. 21215

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-4-1972

24C. NAME OF CEMETERY or CREMATORY

Arbutus Memorial Park

24D. LOCATION

Baltimore Co., Maryland

25A. DATE REC'D BY HEALTH DEPT.

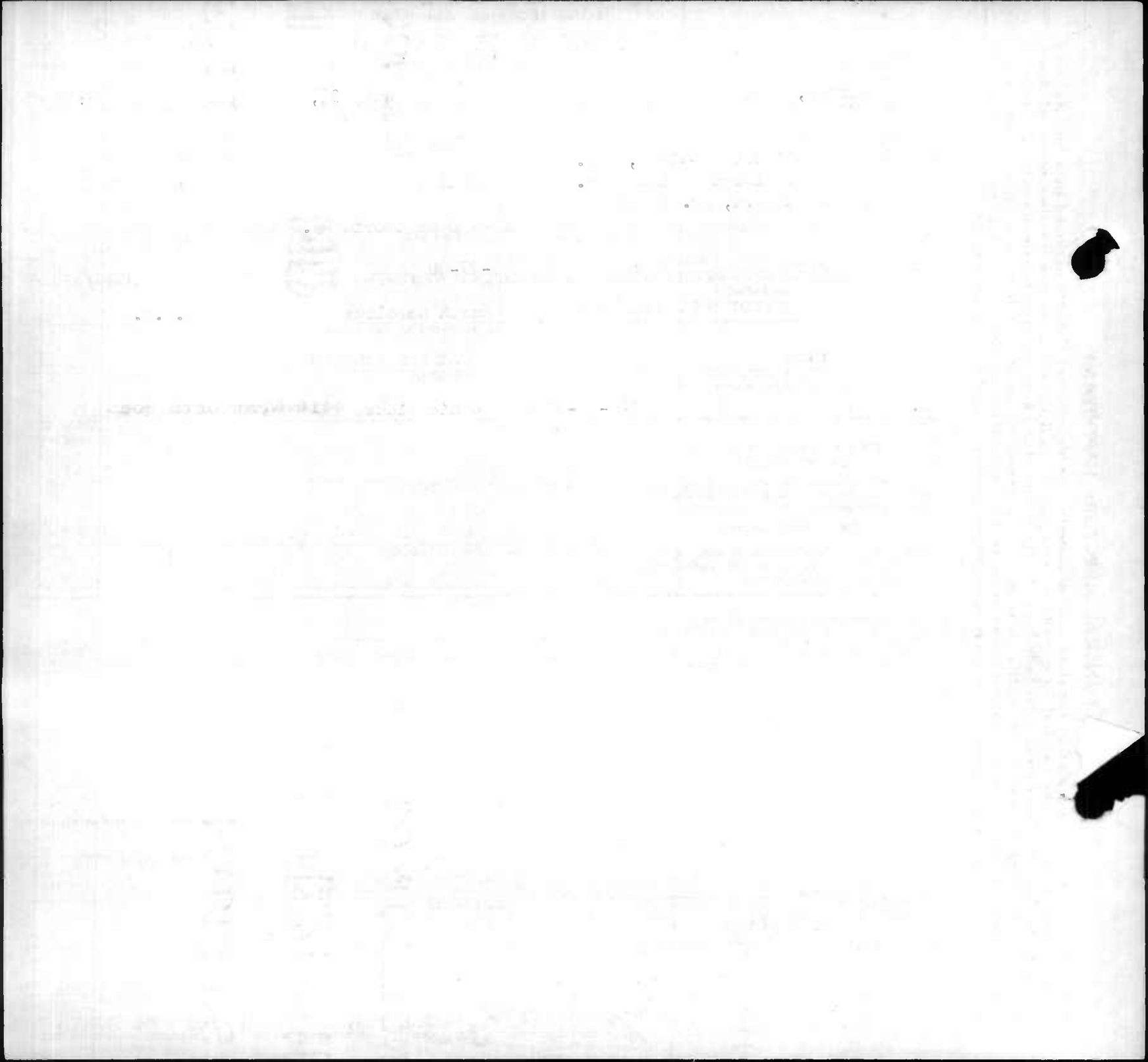
AUG 2 1972

25B. NAME OF REGISTRAR

Sidney H. Portner

25C. FUNERAL DIRECTOR

NUTTER FUNERAL HOME 3035 W. NORTH AVE



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07343 |
|--|--|--|--|---|
| 72 07343 | | | | 72 07343 |
| BIRTH NO. | | REG. NO. | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | |
| Loggins, Mary Agnes | | 7-26-72 12:45AM 12:45A. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | |
| 38 University Hospital Baltimore, Md. | | Md. City 1504 | | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |
| Female | | Negro | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH | | 9. AGE (in years last birthday) | | 10. UNDER 1 Yr. Months: Days |
| 11-4-09 | | 62 | | 11. UNDER 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) |
| Beautician | | Beauty Shop | | Maryland |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | |
| Joshua Levi Johnson | | Pauline Garrett | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| No | | 220-22-5513 | | Leroy B. Loggins 2017 McKean Avenue |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| (This does not mean the mode of dying, e.g., heart failure, pneumonia, etc., but the disease, injury or complication which caused death) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | 6h |
| ANTICIPATED CAUSES | | (B) POSSIBLE BOWEL PERFORATION DUE TO, OR AS A CONSEQUENCE OF: | | 6h |
| DISEASE OR CONDITIONS, if any, giving rise to the above cause (including the UNDERLYING CONDITION last) | | (C) HEAT STROKE AND CIRCUMSPECTION OF LIVER | | 28h YEARS |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| None | | None | | YES |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| None | | None | | None |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? |
| None | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | None |
| 22. I certify that (I) (this hospital) attended the deceased from July 24, 1972 to July 26, 1972 that (I) (we) last saw the deceased alive on July 26, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | |
| Mark Kasowitz M.D. | | 7/26/72 | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | |
| MARK KASOWITZ | | University Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY |
| Burial | | 7-31-72 | | New Cathedral Cemetery |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS |
| AUG 2 1972 | | Sidney B. [unclear] | | NUTTER FUNERAL HOME 3035 W. NORTH AVE |

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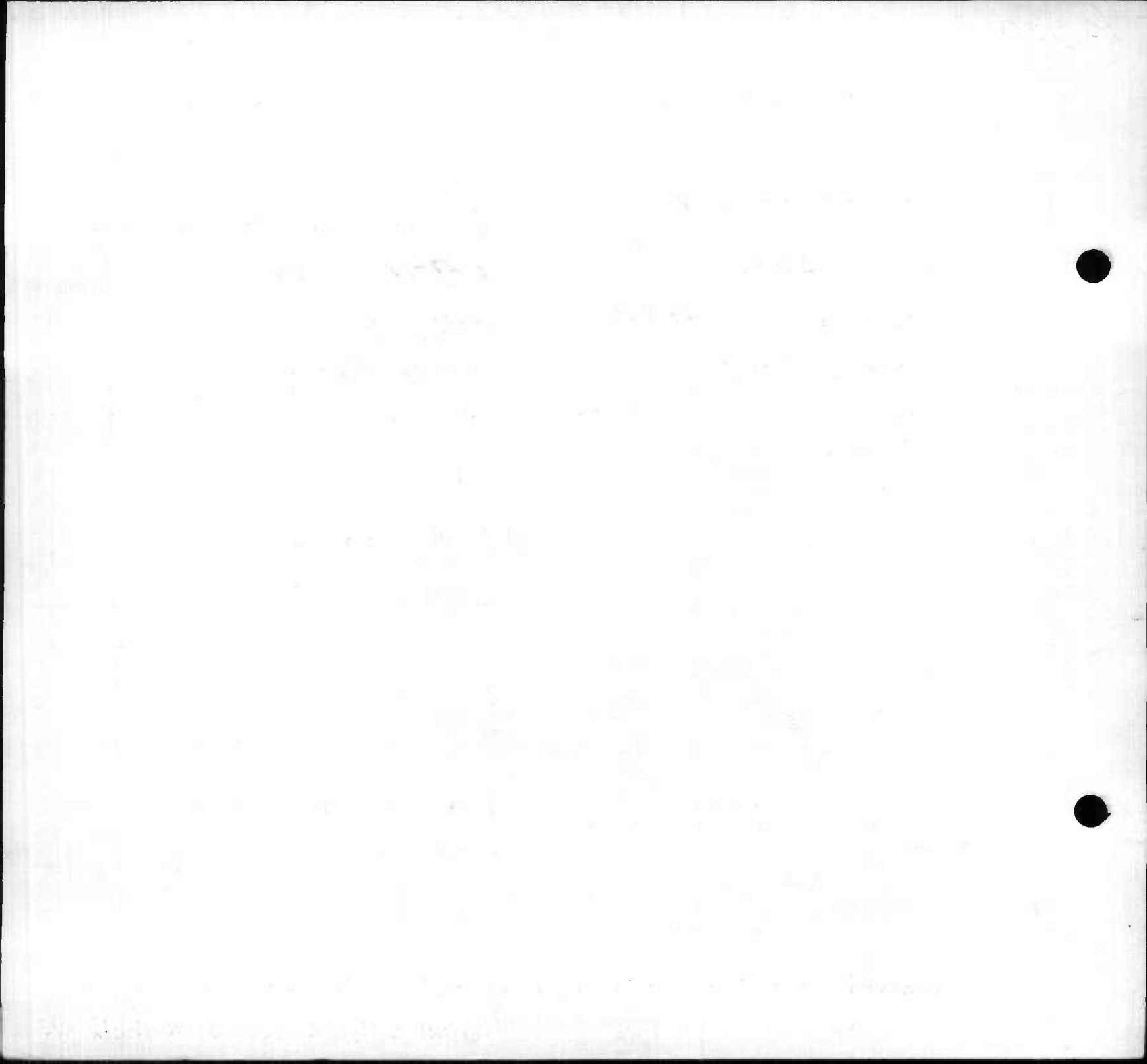
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

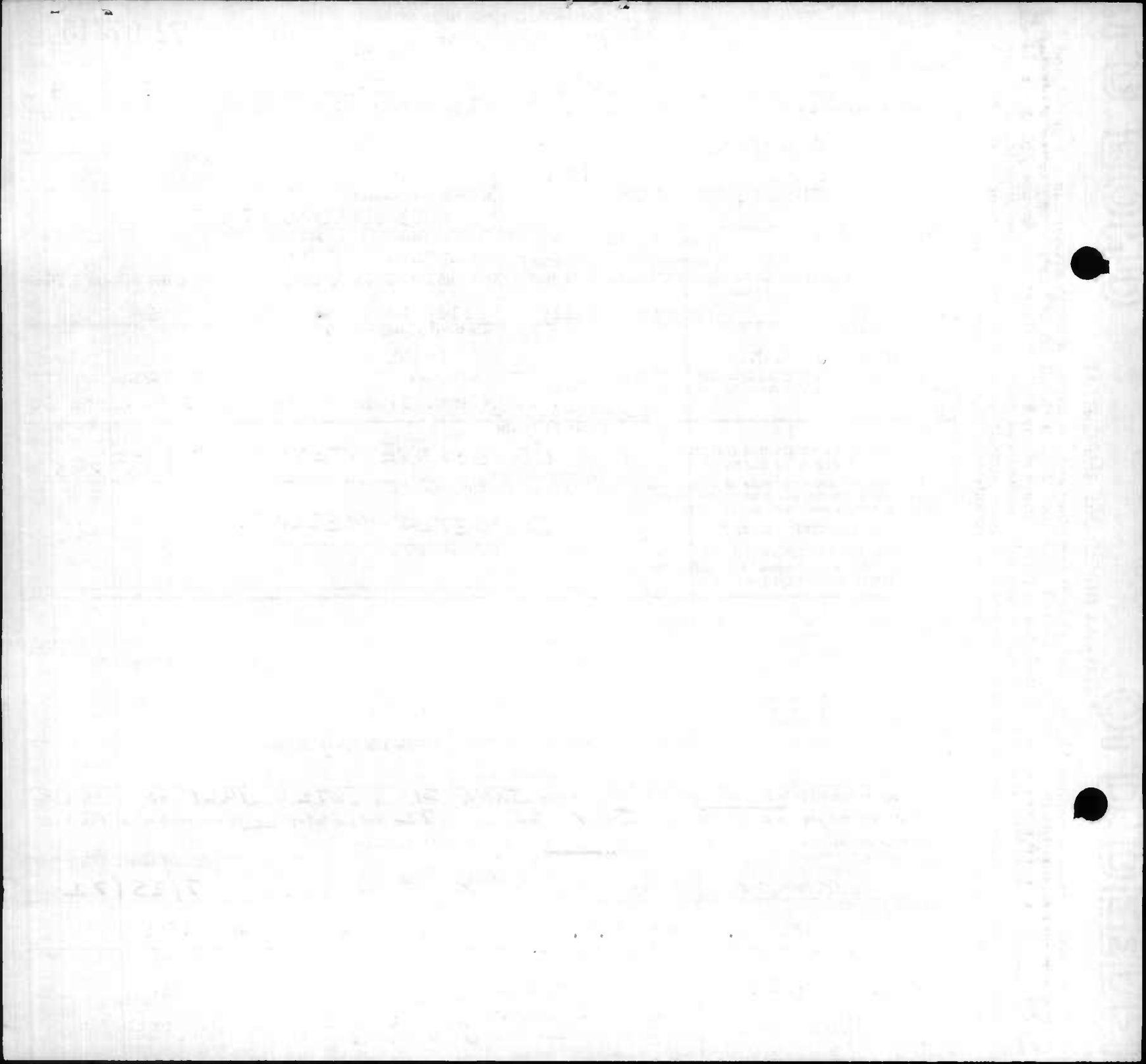
| BALTIMORE CITY HEALTH DEPARTMENT 72 07344 CERTIFICATE OF DEATH STATE OF MARYLAND - DHMH | | | | REG. NO. 72 07344 | |
|---|--|--|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>Pratt, William S.</u> | | 2. DATE AND HOUR OF DEATH <u>7-21-72</u> <u>12:35 A.M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1401</u> | | |
| 5. SEX <u>MALE</u> 6. RACE <u>Black</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH <u>10-27-97</u> 9. AGE In years last birthday <u>74</u> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Waiter</u> | | |
| 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | | 12. CITIZEN OF WHAT COUNTRY | | |
| 13. FATHER'S NAME <u>Solomon Pratt</u> | | | 14. MOTHER'S MAIDEN NAME <u>Nancy Spriggs</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | 16. SOCIAL SECURITY NO. <u>216-07-7439</u> | | |
| 17. INFORMANT <u>Mrs. Mary E. Pratt</u> | | | ADDRESS <u>301 McMechen St</u> | | |
| 18. <u>4299 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE <u>Fever; Uremia renal failure.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Artificial pacemaker.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION <u>7-21-72</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7-18-1972</u> to <u>7-21-1972</u> that (I) (we) last saw the deceased alive on <u>7-20-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Whargave</u> <u>MP</u> DEGREE | | | 23B. DATE SIGNED <u>7-21-72</u> <u>Whargave</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Dr. Gonzalez</u> | | | 23D. ADDRESS | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>6-25-72</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Memorial Park</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore County, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 2 1972</u> | | | |
| 25B. NAME OF REGISTRAR <u>Shirley H. Cotton</u> | | 25C. FUNERAL DIRECTOR <u>Herbert E. Nutter</u> ADDRESS <u>3035-37 W. North Ave</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|---|--|--|---|--|--|--|---|
| 72 07345 | | | | | REG. NO. 72 07345 | | | | |
| BIRTH NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) BANKINS, Marion B. | | | | | 2. DATE AND HOUR OF DEATH JULY 25, 1972 5:15 A.M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1506 | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205 | | | | | C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| E. STREET AND NUMBER 2003 DUKELAND STREET | | | | | | | | | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 08-25-94 | 9. AGE (In years last birthday) 77 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 11. BIRTHPLACE (State or foreign country) Valley Lee, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME THOMAS JORDAN | | | 14. MOTHER'S MAIDEN NAME IRENE CARTER | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 214-28-4155-A | | | 17. INFORMANT ADDRESS Mrs. Irene Mallory 2003 Dukeland St | | | |
| 18. 25071 CAUSE OF DEATH | | | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 YRS. | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. DIABETES MELLITUS | | | | | 1 YR. | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | | | |
| 19A. DATE OF OPERATION 25 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from JUNE 21 19 72 to JULY 25 19 72 that (I) (we) lost saw the deceased alive on JULY 25 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE James K. Brown | | | | | 23B. DATE SIGNED 7/25/72 | | | 23C. PHYSICIAN'S NAME (Type) JAMES K. BROWN M.D. | |
| 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 7/29/72 | | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | | 25B. NAME OF REGISTRAR Andrew Johnson | | | 25C. FUNERAL DIRECTOR ADDRESS Herbert Nutter-3035 W. North Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

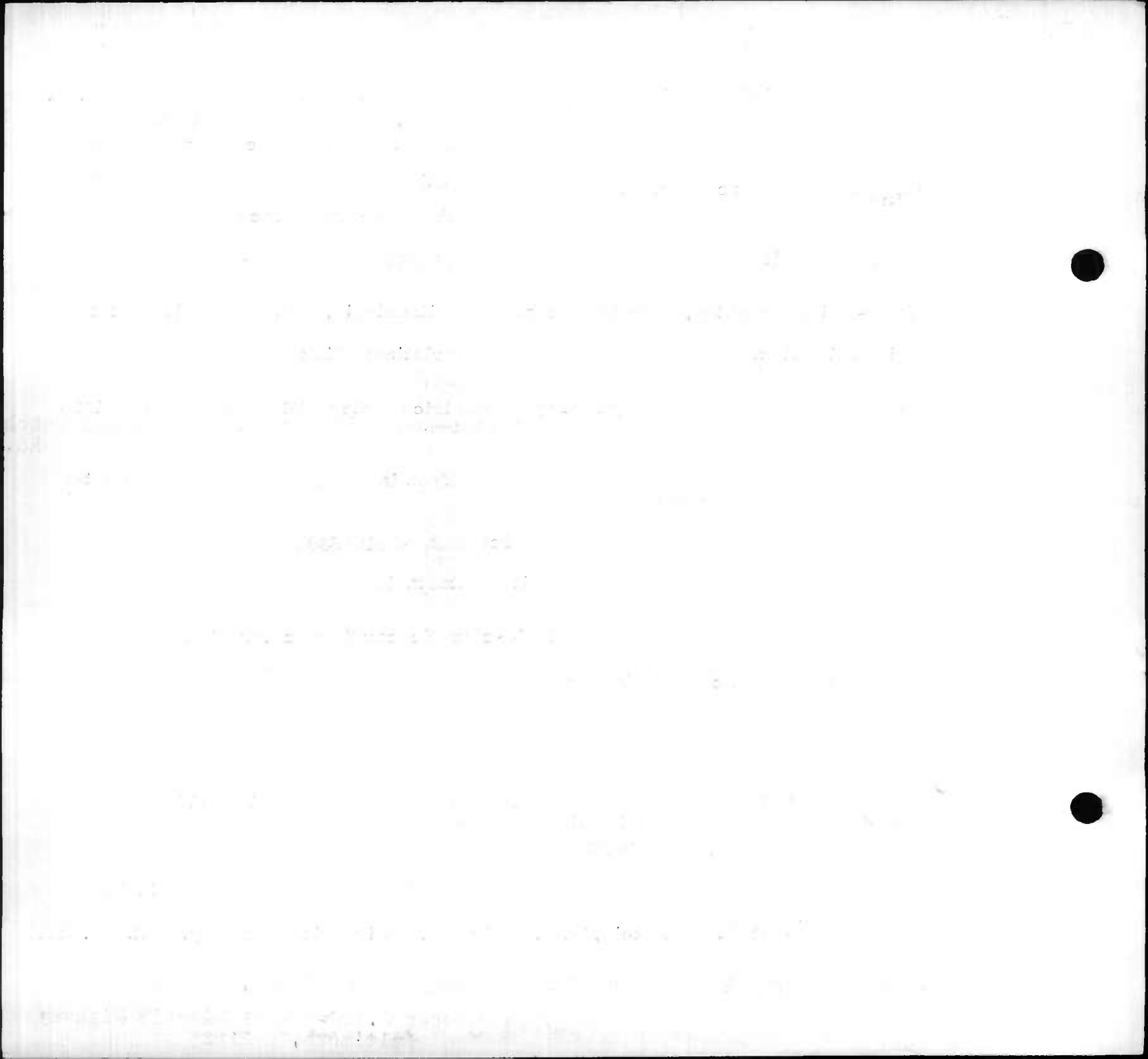
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07346 | | REG. NO. 72 07346 | |
|---|--|---|--|---|--|---|--|
| BIRTH NO. | | D. | | 2. DATE AND HOUR OF DEATH | | 7-31-72 10:30 AM | |
| 1. NAME OF DECEASED (Type or Print) JAMES HAMMETT | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD HILTON NURSING HOME 3313 Poplar Street Baltimore, Maryland 21216 | | | | 5. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 6. RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5-6-90 | | 9. AGE (In years last birthday) 82 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) St. Mary's Co., Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Martin L. Hammett | | | | 14. MOTHER'S MAIDEN NAME Clara J. Bowen | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 219-12-8498-A | | 17. INFORMANT Marie E. Hammett, 1910 Long Corner Rd. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arterio-sclerotic heart disease | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arterio-sclerotic heart disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/19/70 19 to 7/31/72 19, that (I) (we) last saw the deceased alive on 7/31/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>[Signature]</i> | | | | 23B. DATE SIGNED 4/31/72 | | | |
| 23C. PHYSICIAN NAME (Typed) WILLIS BENNARDINE, MD | | | | 23D. ADDRESS 1801 Green Curry Rd Baltimore | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Aug. 3, 1972 | | 24C. NAME OF CEMETERY OR CREMATORY Howard Chapel | | 24D. LOCATION (City, town, or county) (State) Long Corner, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR <i>[Signature]</i> | | 25C. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md. | | ADDRESS | |

8-8-1972 - Correction Letter from Olin L. Molesworth Funeral Home, 26401 Ridge Road,
Damascus, Maryland 20750 - signed by Olin L. Molesworth. HRS

FUNERAL DIRECTOR: IMPORTANT


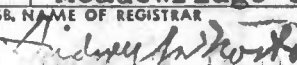
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

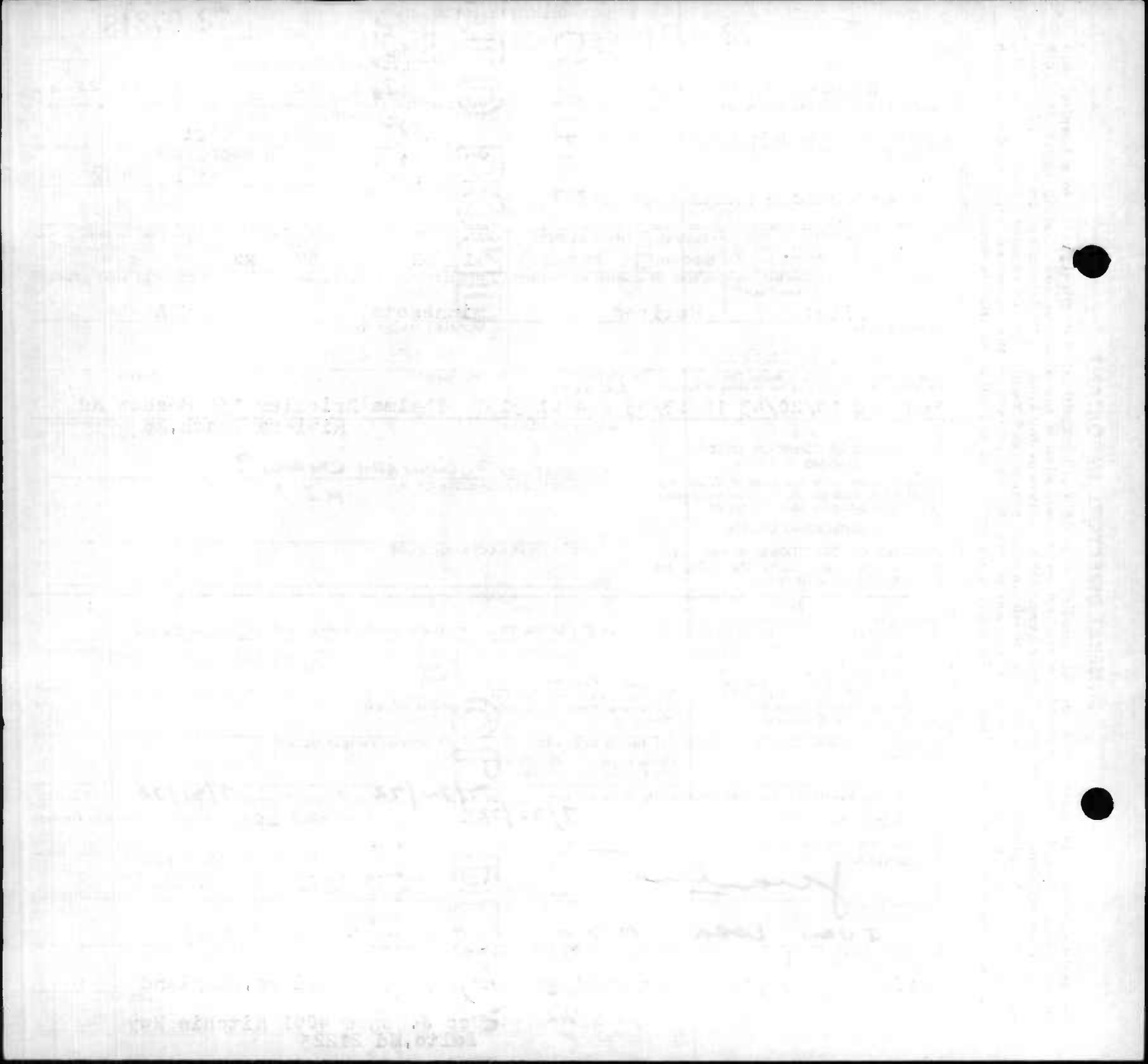
| BALTIMORE CITY HEALTH DEPARTMENT | | 72 07347 | | REG. NO. 72 07347 | |
|--|------------------|---|------------------------------|---|---|
| BIRTH NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | STATE OF MARYLAND - DISTRICT AND HOUR OF DEATH | | | |
| William Geisselman | | 7/30/72 | | 4:45 p.m. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE Md. B. COUNTY Anne Arundel | | | |
| 128 Greenland Beach Road 21226 | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 00 | | E. STREET AND NUMBER 128 Greenland Beach Road 5200 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/10/90 | 9. AGE (in years last birthday) 81 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Retired-Chief Operator, Maryland Glass | | | | Philadelphia, Pa. | |
| 12. CITIZEN OF WHAT COUNTRY? | | United States | | | |
| 13. FATHER'S NAME Louis Geisselman | | 14. MOTHER'S MAIDEN NAME Christiana Fink | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-09-4790 | | 17. INFORMANT Beatrice Duley 113 Weldon Road 21226 | |
| 18. CAUSE OF DEATH | | ADDRESS Florence Geisselman 128 Greenland Beach Rd. | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE Uremia DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Carcinoma of bladder DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) with metastasis | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | Arteriosclerotic cardiovascular disease | | | |
| 19A. DATE OF OPERATION 2/9/72 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer of bladder | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (did not) attended the deceased from 10/15/71 19 to 7/26/72 19 that (I was) lost saw the deceased alive on 7/26/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert B. Goldstein M.D. DEGREE | | | | 23B. DATE SIGNED 7/31/72 | |
| 23C. PHYSICIAN'S NAME (Type) Robert B. Goldstein, M.D. | | | | 23D. ADDRESS 500 W. University Parkway, Balt. Md. 21210 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/3/72 | | 24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR George J. Gonce | | 25C. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Highway Baltimore, Md 21225 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

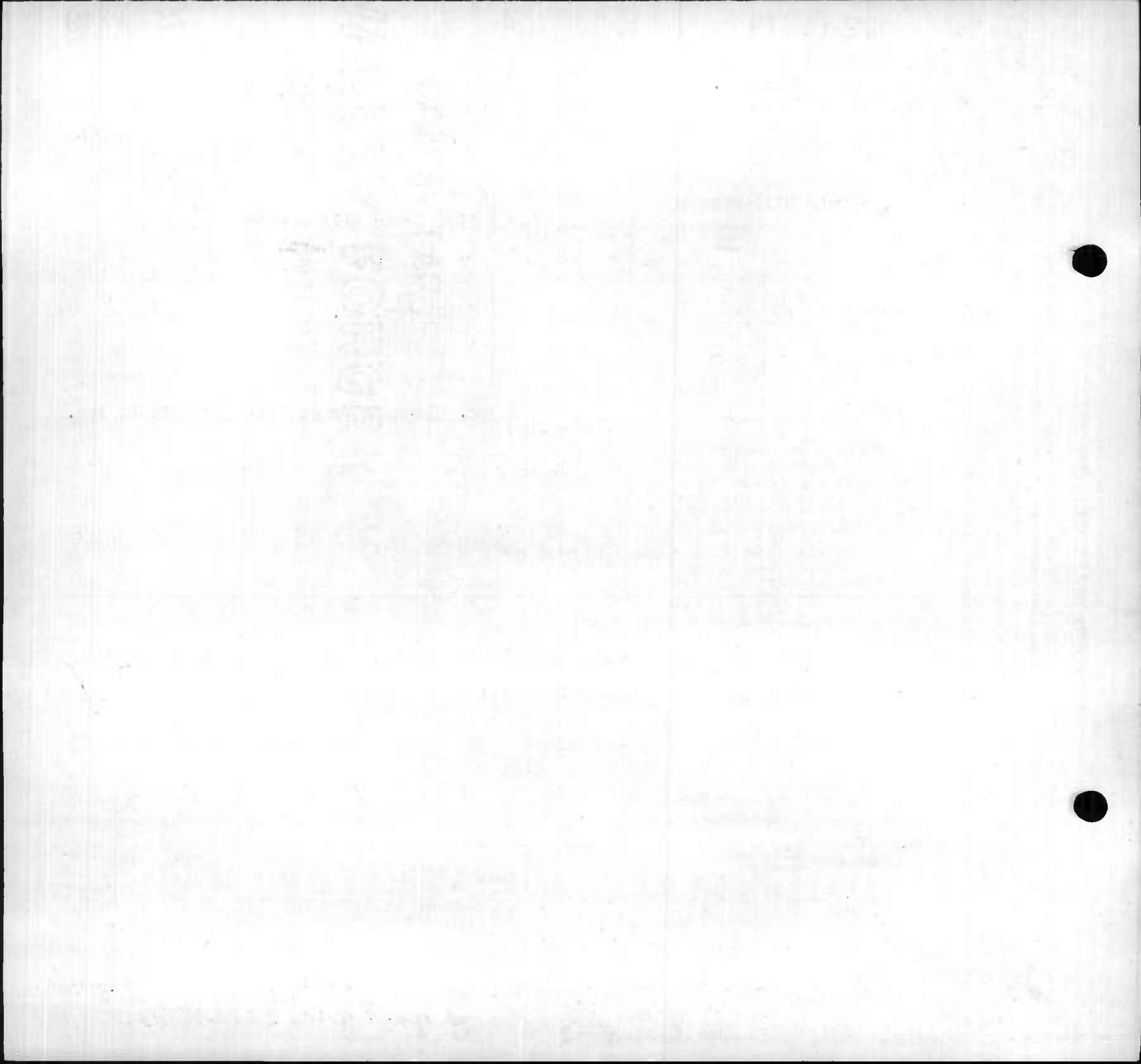
| BIRTH NO. 72 07348 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07348 | | | |
|---|-------------------------|---|---|---|----------------------------|---|-----------------------------|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) KRICKLER, HERMAN | | | | 2. DATE AND HOUR OF DEATH 7/31/72 12.25 A.M. | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital | | | | A. STATE Maryland | | | | B. COUNTY Anne Arundel | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN Rivera Beach | | | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| | | | | E. STREET AND NUMBER 159 Meadow Road | | | | | | | |
| 5. SEX Male | 6. RACE Cauc. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/03/04 | 9. AGE (In years last birthday) 67 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pilot | | | 10B. KIND OF BUSINESS OR INDUSTRY Retired | | | 11. BIRTHPLACE (State or foreign country) Minnesota | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Frank Krickler | | | | 14. MOTHER'S MAIDEN NAME Ada Dunn | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW2 1.0/20/43 1.0/1.3/45 | | | | 16. SOCIAL SECURITY NO. 214 01. 31.97 | | | | 17. INFORMANT Thelma Krickler | | | |
| 18. 170.41 | | | | CAUSE OF DEATH Riviera Beach, Md | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE PULMONARY EMBOLI? DUE TO, OR AS A CONSEQUENCE OF: MI? | | | | | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | | | | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). METASTATIC FIBROSARCOMA OF (R) HUMERUS | | | | | | | | | | | |
| 19A. DATE OF OPERATION 7/28/72 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED INTRACTABLE PAIN | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/20/72 19 to 7/31/72 19 that (I) (we) last saw the deceased alive on 7/30/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE  | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED 7/31/72 | | | |
| 23C. PHYSICIAN'S NAME (Type) JUAN LORA M.D. | | | | 23D. ADDRESS The Johns Hopkins Hospital | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/3/72 | | 24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery | | 24D. LOCATION (City, town, or county) (State) Elkridge, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR  | | 25C. FUNERAL DIRECTOR Geo J. Gonce | | ADDRESS 4001 Ritchie Hwy Balto, Md 21225 | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 72 07349 |
|---|--|--|---|--|
| BIRTH NO. 72 07349 1. NAME OF DECEASED (Type or Print) STATE OF MARYLAND - DEMO Vera M. Broom | | 2. DATE AND HOUR OF DEATH July 24, 1972 M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1102 Druid Hill Avenue | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1702 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1102 Druid Hill Avenue | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-29-02 | 9. AGE (In years lost birthday) 70 69 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Baltimore, Md. | | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | |
| 13. FATHER'S NAME MAJOR RUSS | | 14. MOTHER'S MAIDEN NAME IDA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. Mr. Clarence Jones 1019 Springfield Ave. | | |
| 17. INFORMANT ADDRESS Mr. Clarence Jones 1019 Springfield Ave. | | | | |
| 18. 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Left Coronary Hemorrhage 2 days (B) Hypertensive Coronal Vascular Disease 1 yr (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Excessively Temperature (Weather condition) | | | | |
| 19A. DATE OF OPERATION 7/24/72 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Excessively Temperature (Weather condition) | | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Arbutus, Maryland | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 7/24/72 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/24/72 19 to 7/24/72 19, that (I) (we) lost saw the deceased alive on 7-24-72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE G. Franklin Phillips M.D. | | | | 23B. DATE SIGNED 7/27/72 |
| 23C. PHYSICIAN'S NAME (Type) G. Franklin Phillips M.D. | | | | 23D. ADDRESS 558 McMechan St. Baltimore, Md. |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-27-72 | | |
| 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park | | 24D. LOCATION (City, town, or county) (State) Arbutus, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR Sidney Inwood | | |
| 25C. FUNERAL DIRECTOR Joseph A. Guss 2222 W. North Ave. | | | | |



1
B-152

STATE OF MARYLAND-DEPT.

BALTIMORE CITY HEALTH DEPARTMENT

72 07350

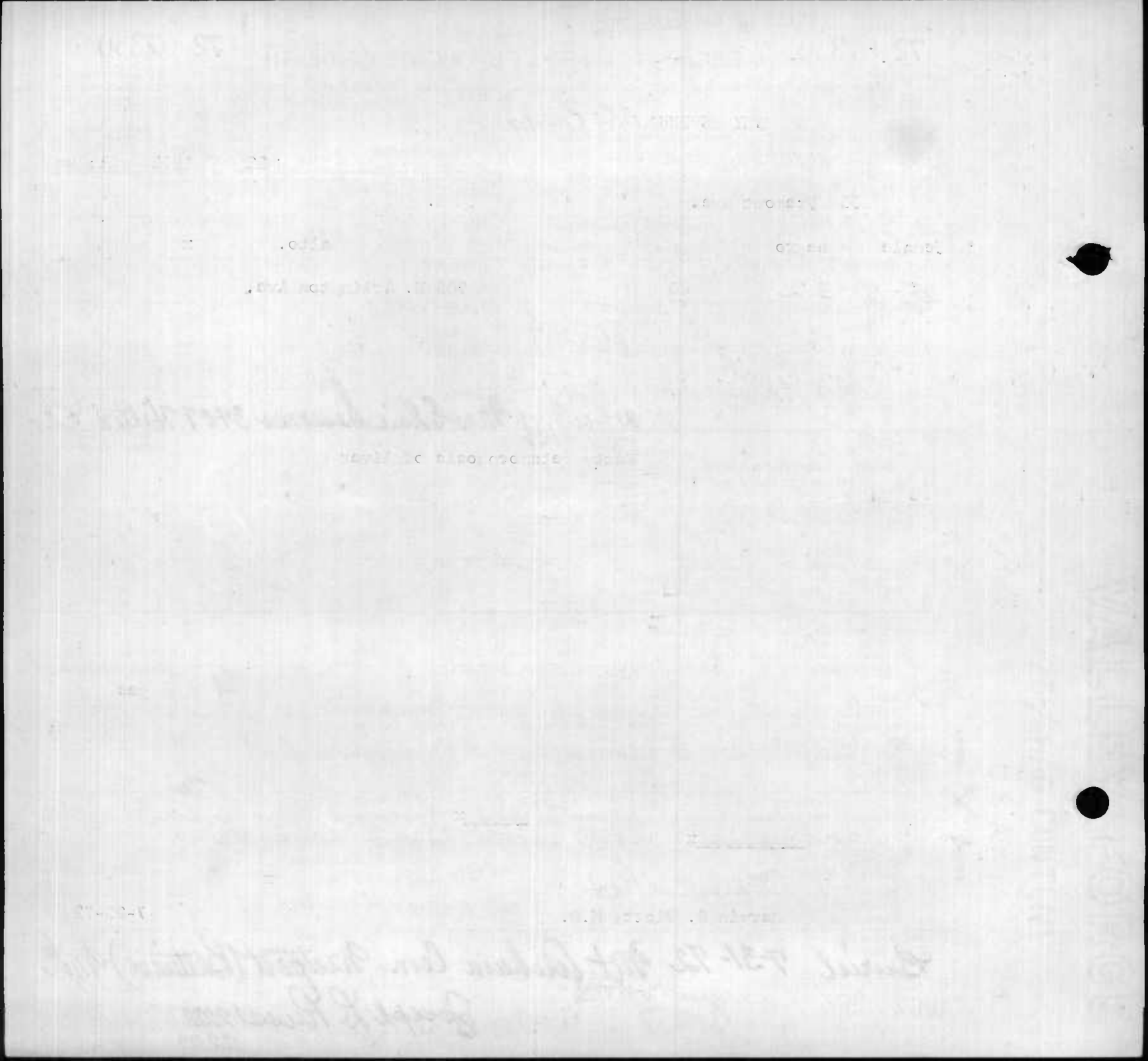
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07350

REG. NO.

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) MARY BEVINS AKA Bevins | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1330 Fremont Ave. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 22 1972 11:40a M. | |
| 6. SEX female | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 7. RACE negro | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 6-5-32 | | 10. AGE (In years last birthday) 40 | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 17. SOCIAL SECURITY NO. 219-01-9496 | | 18. INFORMANT Mrs. Elsie Sessions | |
| 19. 571.81 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver | | ADDRESS 3407 Hilton Rd. | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22D. TIME (Month) (Day) (Year) (Hour) (Approx.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Marvin S. Platt EXAMINER'S NAME (Type) | | DATE SIGNED 7-23-72 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-31-72 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem. | | 24D. LOCATION (City, town, or county) (State) Westport (Baltimore) Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR Joseph L. Russell | |
| 25C. FUNERAL DIRECTOR 2222 W. North Ave. | | ADDRESS 2222 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT 72 07351 STATE OF MARYLAND - DEPT CERTIFICATE OF DEATH | | | | REG. NO. 72 07351 | |
|--|-------------------------|---|---|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>CARVENS, JAMES</u> | | 2. DATE AND HOUR OF DEATH <u>7/21/72</u> <u>8:50</u> A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO.</u> CITY <u>CITY</u> <u>302</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY OF MD</u> | | | C. CITY OR TOWN <u>CITY</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER <u>1048 E PRATT ST</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5/6/01</u> | 9. AGE (in years last birthday) <u>71</u> | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u> | | 11. BIRTHPLACE (State or foreign country) <u>Alabama</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. <u>215-10-9889</u> | | 17. INFORMANT <u>CHART</u> |
| 18. <u>410.91</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE <u>Acute MI</u> DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> |
| | | | (B) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF: | | <u>yes</u> |
| | | | (C) _____ | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>CHF, EMPHYSEMA</u> | | | | | |
| 19A. DATE OF OPERATION <u>21</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>TRANSVENOUS PACEMAKER FOR BRADYCARDIA</u> | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Lawrence A. Fleming MD</u> DEGREE | | | 23B. DATE SIGNED <u>7/21/72</u> | | 23C. PHYSICIAN'S NAME (Type) <u>LAWRENCE A. FLEMING MD</u> DEGREE |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 24B. DATE <u>7-26-72</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Vernon Cem.</u> |
| 24D. LOCATION (City, town, or county) (State) <u>Westport (Baltimore) Md</u> | | | 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 2 1972</u> | | |
| 25B. NAME OF REGISTRAR <u>Wm. J. [illegible]</u> | | | 25C. FUNERAL DIRECTOR <u>James H. [illegible]</u> ADDRESS <u>2222 N. [illegible]</u> | | |

10/11/72 - Operation performed

7/18/72

Letter from University Hosp - Filed
in Bur. of Biostatistics.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-1201

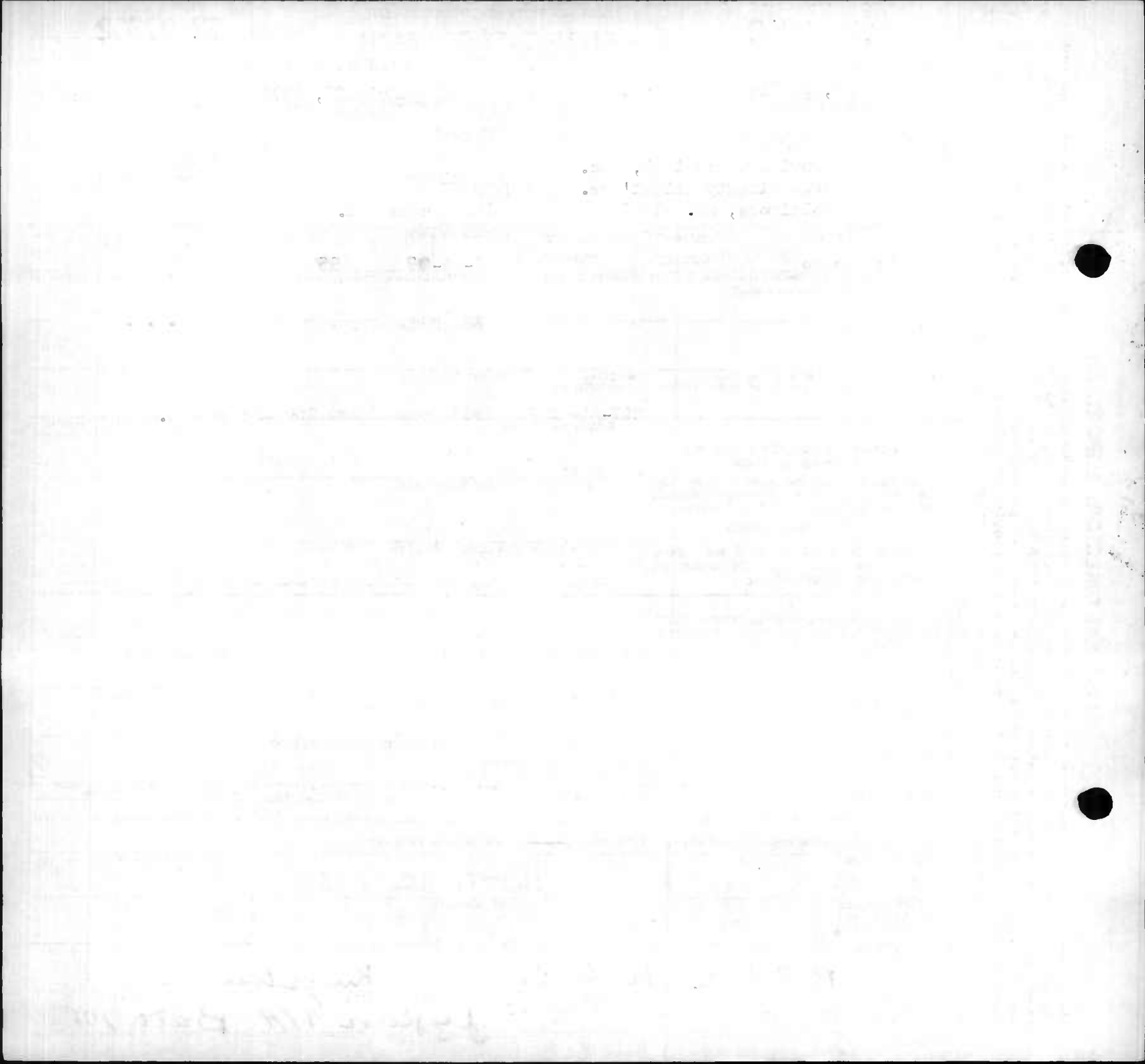
72 07352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

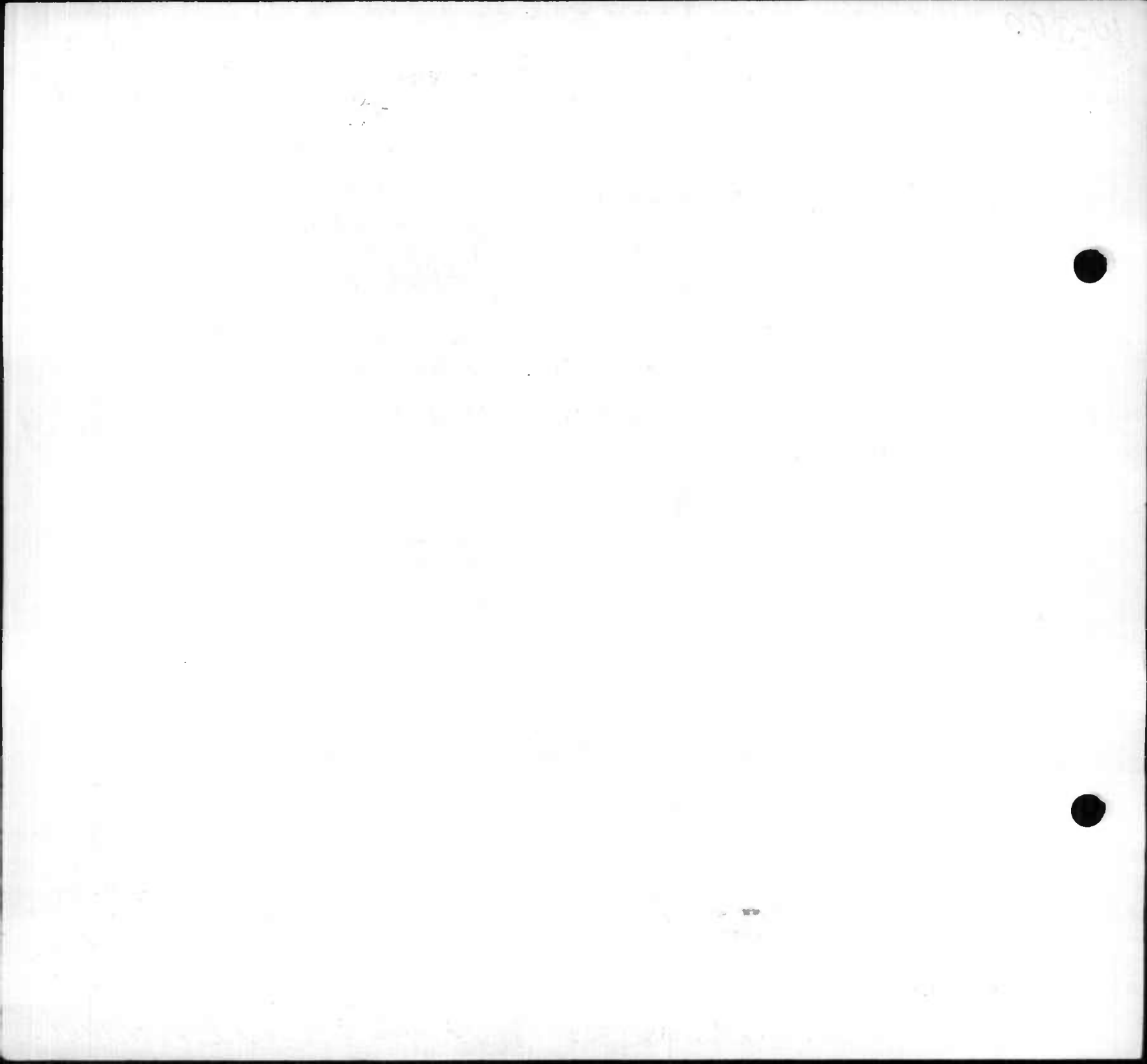
REG. NO. 72 07352

| | | | |
|---|----------------------|---|---|
| BIRTH NO. 72 07352 | | STATE OF MARYLAND | |
| 1. NAME OF DECEASED (Type or Print) Epps, Nellie (Nellie) | | 2. DATE AND HOUR OF DEATH July 27, 1972 2:45 PM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. 2600 Liberty Height Ave. Baltimore, Md. 21215 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1502 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1604 McKean St. AVE | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-16-07 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 65 If Under 1 Yr. Months: Days: Hours: Min. |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 247-84-2847 | 17. INFORMANT Fred Green (SON) ADDRESS 1604 McKean St. |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 250.91 Chronic Renal Failure & Chemia | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unknown | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive Cardiovascular Disease & C.H.F. - unknown | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus unknown | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION 2 none | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-12 19 72 to 7-27 19 72 that (I) (we) last saw the deceased alive on 7-27 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Aurora C. Tan, M.D. | | 23B. DATE SIGNED 7-27-72 | |
| 23C. PHYSICIAN'S NAME (Type) AURORA C. TAN, M.D. | | 23D. ADDRESS Provident Hospital, Baltimore, Md. 21215 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) B | | 24B. DATE 7/30/72 | |
| 24C. NAME OF CEMETERY OR CREMATORY Chapel Ce | | 24D. LOCATION (City, town, or county) (State) Kingstree SC | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR Edna H. Boston | |
| 25C. FUNERAL DIRECTOR J. J. Rugg F/H | | ADDRESS Bath Md | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

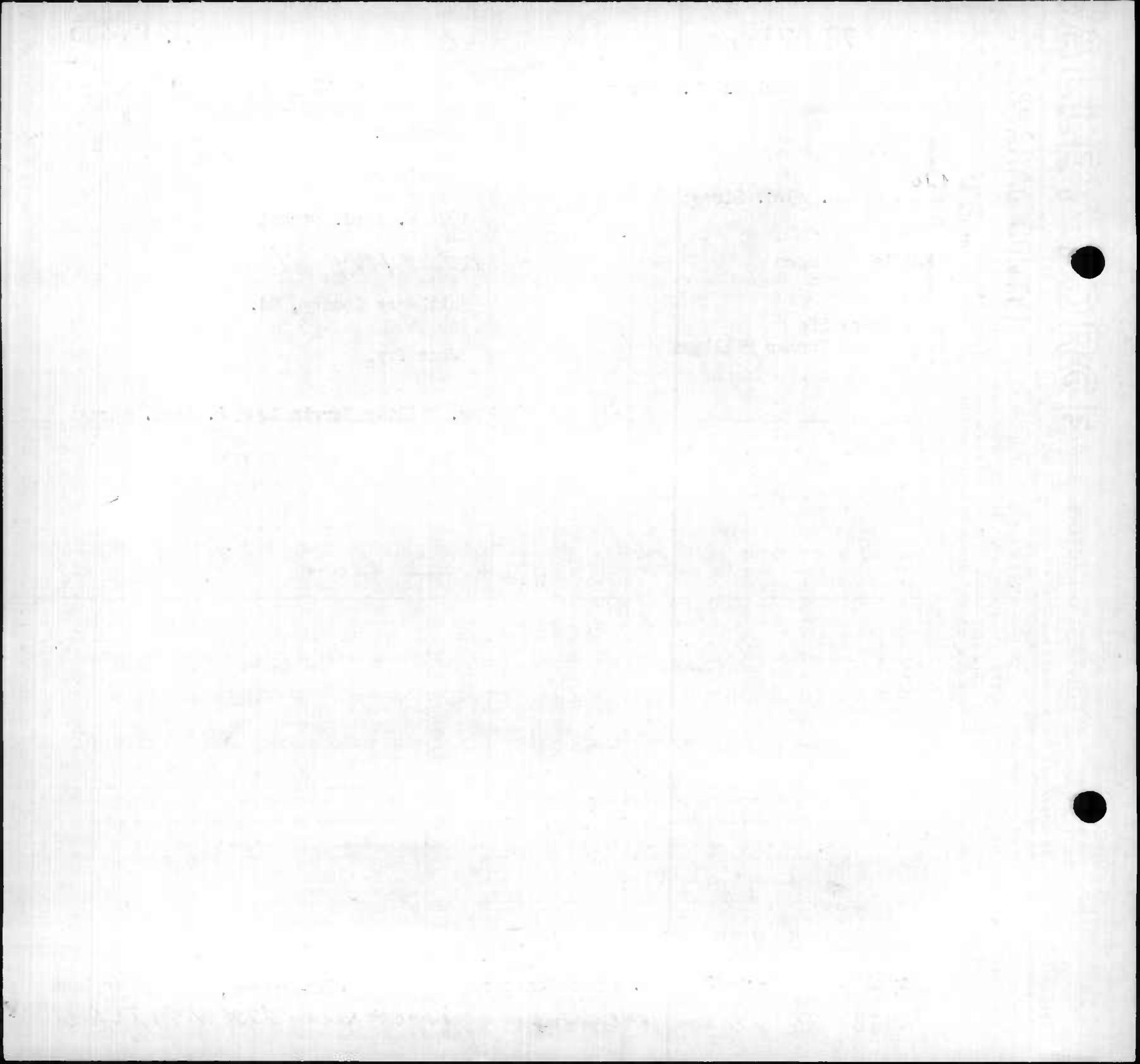
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>72 07354</u> | |
|--|--|--|--|--|--|
| BIRTH NO. <u>72 07354</u> | | | | STATE OF <u>MARYLAND</u> <u>DIME</u> | |
| 1. NAME OF DECEASED (Type or Print) <u>Lillian Wyatt</u> | | | | 2. DATE AND HOUR OF DEATH <u>July 24, 1972 7:30 A.M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hosp.</u> | | | | A. STATE <u>Maryland</u> B. COUNTY <u>1702</u> | |
| C. CITY OR TOWN <u>Baltimore</u> | | | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER <u>1938 Druid Hill Ave.</u> | | | | | |
| 5. SEX <u>Female</u> | | 6. RACE <u>Negro</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH <u>June 1904</u> | | 9. AGE (In years last birthday) <u>68</u> | | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY | | 13. FATHER'S NAME <u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Minnie Smith</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>213-26-3110</u> | | 17. INFORMANT <u>Mr. Robert C. Wyatt</u> ADDRESS <u>1338 Druid Hill</u> | |
| 18. <u>412.21</u> CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| (A) IMMEDIATE CAUSE <u>Hyperkalemia Cardiac</u> DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (B) <u>Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (C) _____ | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>no</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1975</u> to <u>1972</u> that (I) (we) last saw the deceased alive on <u>7/7/72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>WAYLAND E. JONES, M.D.</u> | | | | 23B. DATE SIGNED <u>7/28/72</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>1300 N. FREMONT AVE. BALTIMORE, MD. 21213</u> | | | | 23D. ADDRESS <u>1300 N. Fremont</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY <u>Arbiter Memorial Park</u> | |
| 24D. LOCATION (City, town, or county) <u>Arbiter</u> | | 24E. LOCATION (State) <u>MD.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 2 1972</u> | |
| 25B. NAME OF REGISTRAR <u>Nancy Winston</u> | | 25C. FUNERAL DIRECTOR <u>Joseph A. Ruess</u> | | 25D. ADDRESS <u>2222 W. North Ave.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 72 07355 | | | | | | | | | | Baltimore City Health Department | | | | | | | | | | REG. NO. 72 07355 | | | | | | | | | |
|--|--|---------|--|---|--|------------------|--|----------------------------------|--|--|--|-----------------------------|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) | | | | | | | | | | 2. DATE AND HOUR OF DEATH | | | | | | | | | | | | | | | | | | | |
| Corinne D. Harris | | | | | | | | | | 7-22-72 5:50P M. | | | | | | | | | | | | | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | | | | | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | | | | | | | A. STATE B. COUNTY | | | | | | | | | | | | | | | | | | | |
| 1006 E. 43rd. Street | | | | | | | | | | Maryland | | | | | | | | | | | | | | | | | | | |
| C. CITY OR TOWN | | | | | | | | | | D. INSIDE CITY LIMITS? | | | | | | | | | | | | | | | | | | | |
| Baltimore | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| E. STREET AND NUMBER | | | | | | | | | | 2710 | | | | | | | | | | | | | | | | | | | |
| 1006 E. 43rd. Street | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years, lost birthday) | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | | | | | | | | | | | | | | | |
| Female | | Negro | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Oct 27, 1889 | | 81 | | | | | | | | | | | | | | | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | | | | | | 11. BIRTHPLACE (State or foreign country) | | | | | | | | | | | | | | | | | | | |
| Housewife | | | | | | | | | | Baltimore County, Md. | | | | | | | | | | | | | | | | | | | |
| 13. FATHER'S NAME | | | | | | | | | | 14. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | |
| Thomas Milligan | | | | | | | | | | Jane Frye | | | | | | | | | | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | | | | | | 16. SOCIAL SECURITY NO. | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | 212-32-39815 | | | | | | | | | | | | | | | | | | | |
| 17. INFORMANT | | | | | | | | | | ADDRESS | | | | | | | | | | | | | | | | | | | |
| Mr. William Harris | | | | | | | | | | 1006 E. 43rd. Street | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | | | | | | arterio sclerosis | | | | | | | | | | | | | | | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) | | | | | | | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | | | | | | | | | | | | | |
| ANTECEDENT CAUSES | | | | | | | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | | | | | | | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | (C) heart fail failure | | | | | | | | | | | | | | | | | | | |
| II | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | | | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | | | | | | | | | | |
| 20A. AUTOPSY? (Yes or No) | | | | | | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | | | | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | | | | | | | | | | | | | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | | | | | | 21E. INJURY OCCURRED | | | | | | | | | | | | | | | | | | | |
| While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | | | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE | | | | | | | | | | 23B. DATE SIGNED | | | | | | | | | | | | | | | | | | | |
| Lay Martin | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | | | | | 23D. ADDRESS | | | | | | | | | | | | | | | | | | | |
| Lay Martin | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | | | | | | | 24B. DATE | | | | | | | | | | | | | | | | | | | |
| Burial | | | | | | | | | | 7-25-72 | | | | | | | | | | | | | | | | | | | |
| 24C. NAME OF CEMETERY or CREMATORY | | | | | | | | | | 24D. LOCATION (City, town, or county) (State) | | | | | | | | | | | | | | | | | | | |
| St. Lukes Cemetery | | | | | | | | | | Reisterstown, Maryland | | | | | | | | | | | | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | | | | | | | 25B. NAME OF REGISTRAR | | | | | | | | | | | | | | | | | | | |
| AUG 2 1972 | | | | | | | | | | Lay Martin | | | | | | | | | | | | | | | | | | | |
| 25C. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | | | | | | | | | | | | | | | | | | |
| Joseph H. Kues | | | | | | | | | | 2222 W. North Ave | | | | | | | | | | | | | | | | | | | |



1
B-550

72 07356

STATE OF MARYLAND - DEPT.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07356

BIRTH NO.

REG. NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Burnise Burnise Bowman | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 7 Day 28 Year 72 Hour 12:00A. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital | | 3. DATE PRONOUNCED DEAD Month 7 Day 28 Year 72 Hour 12:00 A. M. | |
| 6. SEX Male | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Maryland B. COUNTY 1601 | |
| 9. DATE OF BIRTH March 5, 1912 | | 10. AGE (in years last birthday) 60 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) South Carolina | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 13. FATHER'S NAME Sidney Bowman | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 15. MOTHER'S MAIDEN NAME Connie Marshall | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT ADDRESS Evelyn Stevenson 4020 Colborne Road | |
| 19. E965X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Gunshot of chest DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street | |
| 22D. TIME OF INJURY (APPROX.) 7 27 72 P. m. | | 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? 718-720 Fremont Ave. | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Shot by unknown assailant | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE W P Mulloy M.D. EXAMINER'S NAME (Type) William P. Mulloy, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-28-72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-1-72 | |
| 24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR Sidney In... | |
| 25C. FUNERAL DIRECTOR Arlington S. Phillips | | ADDRESS 1727 N. Monroe Street | |

N 875.1

0300 37

0300 37



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07357

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 07357

BIRTH NO.

1. NAME OF DECEASED STATE OF MARYLAND-DHMH
(Type or Print)

2. DATE AND HOUR OF DEATH

July 31 1972

2:50 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
Barksdale, Clifton

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland
B. COUNTY 1509

FULL NAME OF HOSPITAL OR INSTITUTION
39
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION
Provident Hospital, Inc.
2600 Liberty Height Ave.
Baltimore, Md. 21215

C. CITY OR TOWN Baltimore

D. INSIDE CITY LIMITS? YES ☐ NO ☐

E. STREET AND NUMBER 3800 Norfolk Ave.

5. SEX
Male

6. RACE
Negro

7. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

9. AGE (In years last birthday) 57

10. Under 1 Yr. Months: Days
11. Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machinist

10B. KIND OF BUSINESS OR INDUSTRY
Crown, Cork & Seal

11. BIRTHPLACE (State or foreign country)
Virginia

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

John Barksdale

14. MOTHER'S MAIDEN NAME

Mary

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes
1941-1944

16. SOCIAL SECURITY NO.
213-12-6813

17. INFORMANT ADDRESS

Mary Barksdale (WIFE) 3800 Norfolk Ave.

18. 519.3

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Respiratory Failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

Chronic Obstructive Airway Disease

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

Renal failure & COPD.

19A. DATE OF OPERATION
0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)
No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

White At ☐ Not White At ☐
Work Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 30, 19 72 to July 31, 19 72 that (I) (we) last saw the deceased alive on 7.31 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M. J. Shafi

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

7/31/72

23C. PHYSICIAN'S NAME (Type)

Shafi M.D.

23D. ADDRESS

Provident Hospital 2600 Liberty Height Ave.

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

8/5/72

24C. NAME OF CEMETERY OR CREMATORY

Carver Mem. Park

24D. LOCATION

Laurel, Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 2 1972

25B. NAME OF REGISTRAR

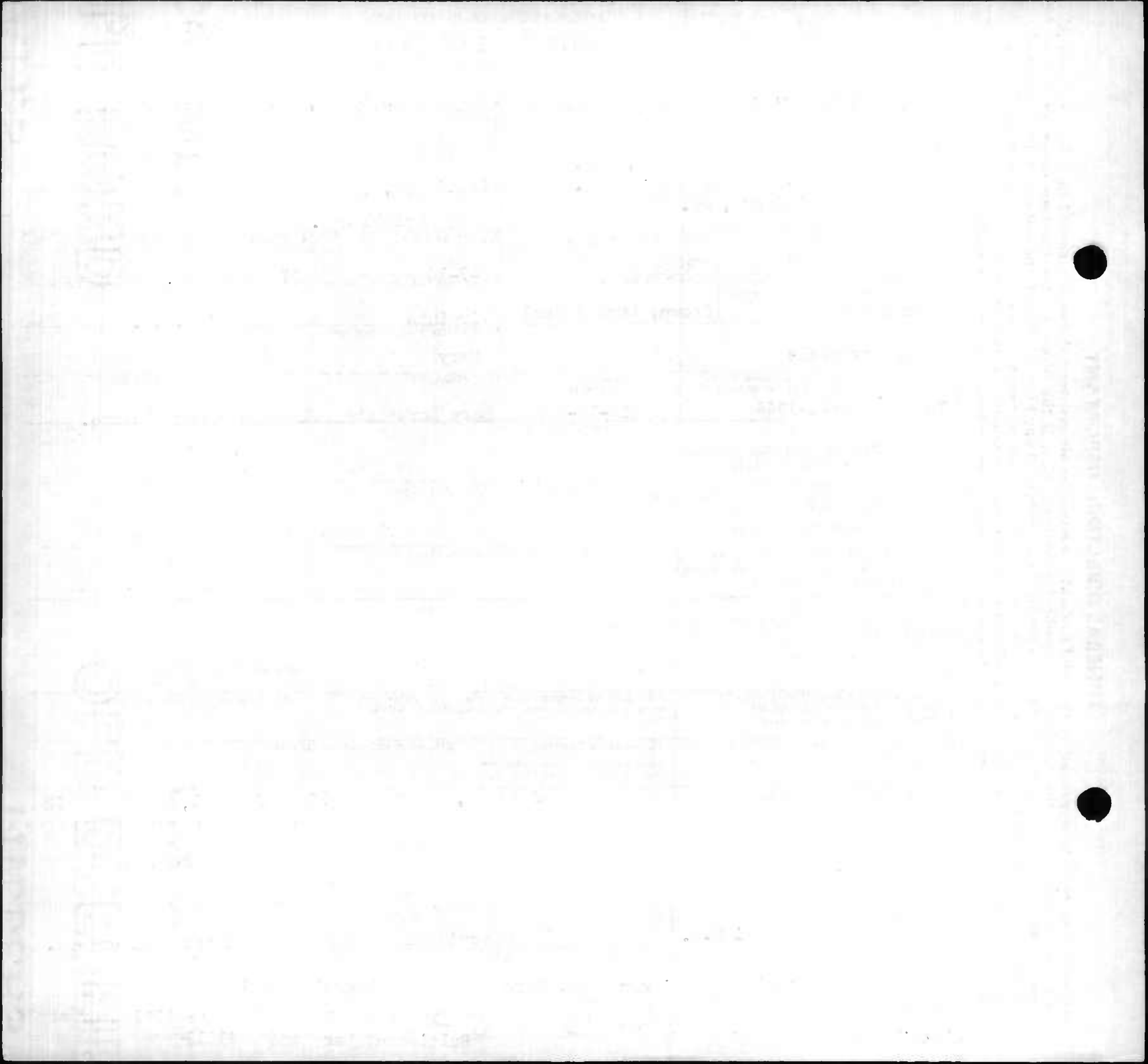
Sidney H. Heston

25C. FUNERAL DIRECTOR

MORTON & DYETT FUNERAL HOME 1701 Laurens St.

ADDRESS

Baltimore, Maryland 21217



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

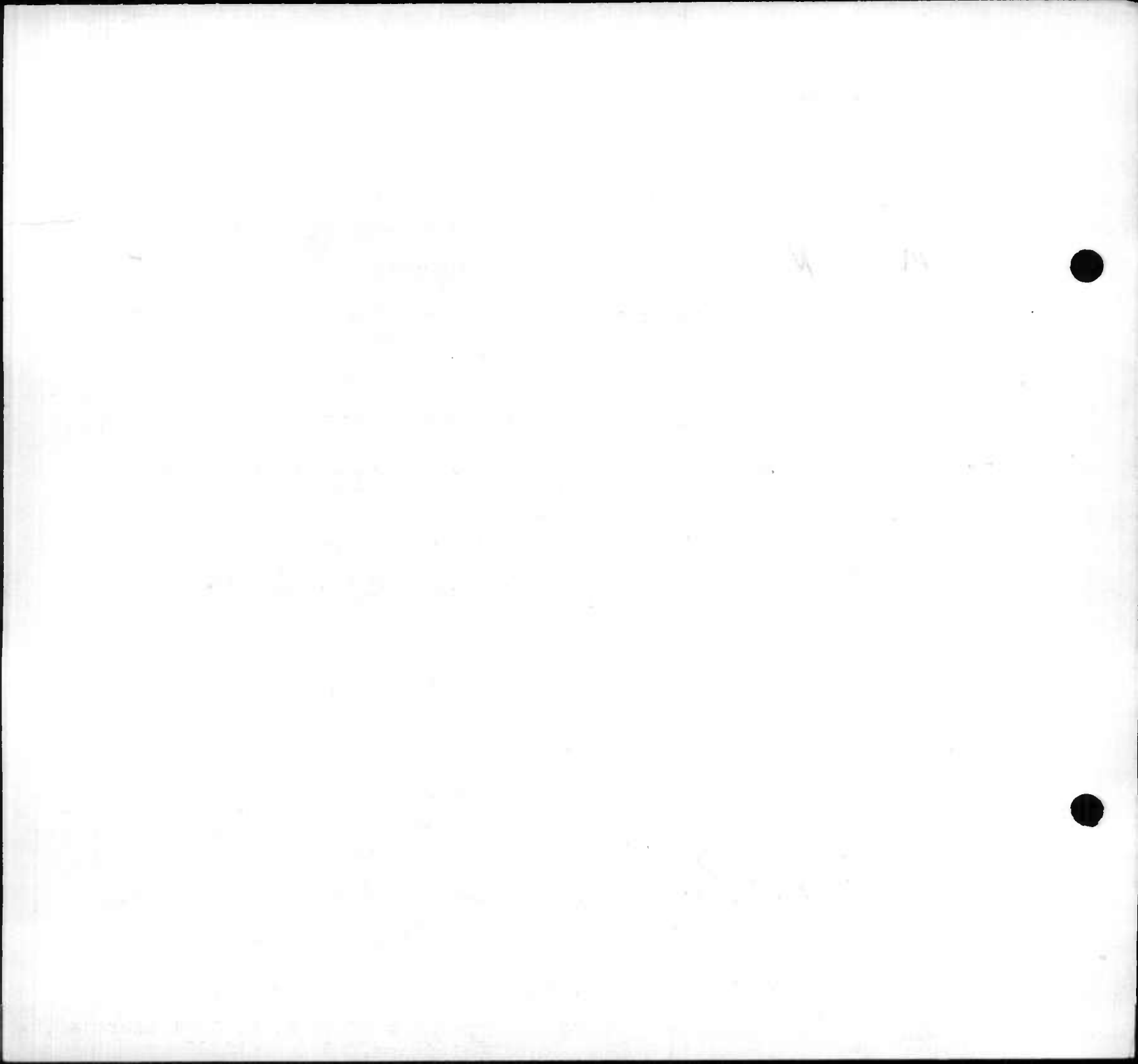
S-152 1

72 07358

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 07358

| | | | |
|---|--|--|---|
| BIRTH NO. 72 07358 | | STATE OF MARYLAND | |
| 1. NAME OF DECEASED (Type or Print) SPENCE, Therman | | 2. DATE AND HOUR OF DEATH 8/1/72 | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital 735 Ashburton St., Balto., Md. 21216 | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Maryland B. COUNTY 2802 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4506 Wentworth Road | |
| 5. SEX M | 6. RACE N | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/22/1915 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman | | 10B. KIND OF BUSINESS OR INDUSTRY Merchant Marine | 9. AGE (In years last birthday) 56 If Under 1 Yr. Months: Days: Hours: Min. |
| 11. BIRTHPLACE (State or foreign country) South Mills, N. C. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Elijah Spence | | 14. MOTHER'S MAIDEN NAME Addie | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 216 09 8297 | 17. INFORMANT Dorothy Spence ADDRESS SAME |
| 18. 410.01 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE: Myocardial infarction (B) DUE TO, OR AS A CONSEQUENCE OF: Coronary atherosclerosis (C) Hypertensive Cv disease | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1950 to July 31, 1972 that (I) (we) last saw the deceased alive on July 21, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE J. Shorofsky MD | | 23B. DATE SIGNED 7/31/72 | |
| 23C. PHYSICIAN'S NAME (Type) Shorofsky | | 23D. ADDRESS 473 PARK Hgts 21215 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 8/5/72 | 24C. NAME of CEMETERY or CREMATORY Arbutus Me. Park | 24D. LOCATION (City, town, or county) (State) Arbutus, Md. 21227 |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | 25B. NAME OF REGISTRAR Lidney | 25C. FUNERAL DIRECTOR MORTON & DYETT F. H. ADDRESS 1701 Laurens St. Baltimore, Md. 21217 |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|---------------------|---|-------------------------------------|--|--|---|--|
| 72 07359 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | REG. NO. 72 07359 | |
| BIRTH NO. STATE OF MARYLAND-DHMH | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Thelma Mack</u> | | | | 2. DATE AND HOUR OF DEATH <u>8/1/72</u> <u>6:15 P.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University Hospital</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1325 W. Mosher Street</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-19-16</u> | 9. AGE (In years last birthday) <u>55</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Lewis Thomas</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Ethel</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Glenn Mack</u> ADDRESS | | |
| 18. <u>410.9 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiogenic Shock</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> | |
| | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Myocardial Infarction</u> | | <u>6 hours</u> | |
| | | | | (C) | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>8/1/72</u> to <u>8/1/72</u> that (I) (we) last saw the deceased alive on <u>8/1/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Mark H. Kasowitz</u> DEGREE | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>8/1/72</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>MARK H. KASOWITZ MD</u> | | | | 23D. ADDRESS <u>University Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>8-5-72</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Westport Cem.</u> | | 24D. LOCATION (City, town, or county) (State) <u>Westport, Md. 21225</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 2 1972</u> | | 25B. NAME OF REGISTRAR <u>72000</u> | | 25C. FUNERAL DIRECTOR <u>Baltimore Street F.H. 1201</u> | | ADDRESS | |

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M-620

72 07360

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07360

| | | | | | |
|---|-------------------------|--|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) MARY MORRIS | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1525 W. Saratoga St. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 31 1972 7:50a M. | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1901 | |
| 6. SEX female | 7. RACE negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 8/1/1904 | | 10. AGE (In years lost birthday) 67 | | E. STREET AND NUMBER 1525 W. Saratoga St. | |
| 11. BIRTHPLACE (State or foreign country) Middlesex, Va. XXXXXXXXXXXX | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Squire Morris | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME Lucille | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 219280728 | | 18. INFORMANT ADDRESS Squire Morris, Jr. 1922 N. Fulton Av. | |
| 19. 412.41 CAUSE OF DEATH Arteriosclerotic cardiovascular disease (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) no | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7-31-72 EXAMINER'S NAME (Type) Marvin S. Platt, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 8/2/72 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pk. | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. 21227 | | 25A. DATE REC'D BY HEALTH DEPT. AUG 2 1972 | | | |
| 25B. NAME OF REGISTRAR Shirley M. [Signature] | | 25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT FUNERAL HOMES, INC. 1701-31 Laurens St., 21217 | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|----------------------|---|--|--|---|
| A-300 72 07361 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 72 07361 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Dorothy DeWitt Adt | | July 23, 1972 11 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Long Green Nursing Home 115 E. Melrose Avenue | | | A. STATE Maryland | | |
| | | | B. COUNTY 1201 | | |
| | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 116 W. University Parkway | | |
| 5. SEX Female | 6. RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 20, 1895 | 9. AGE (In years last birthday) 76 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Charles DeWitt | | | 14. MOTHER'S MAIDEN NAME Ruth March | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216-05-2876 | 17. INFORMANT Patricia A. Funk | | |
| | | | ADDRESS Montrose Ave. 21212 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Cancer of Lung DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Year | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 50 to July 23, 19 72, that (I) (we) last saw the deceased alive on July 22, 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE William G. Helfrich, M.D. | | | | 23B. DATE SIGNED July 24, 1972 | |
| 23C. PHYSICIAN'S NAME (Type) William G. Helfrich, M.D. | | | | 23D. ADDRESS 5006 Roland Avenue 21210 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation | | 24B. DATE 7-24-72 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park Crematory | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 3 1972 | | 25B. NAME OF REGISTRAR Andrew W. Horton | | 25C. FUNERAL DIRECTOR Wm. Cook-Brooks 1050 York Rd. Towson, Md. 21204 | |

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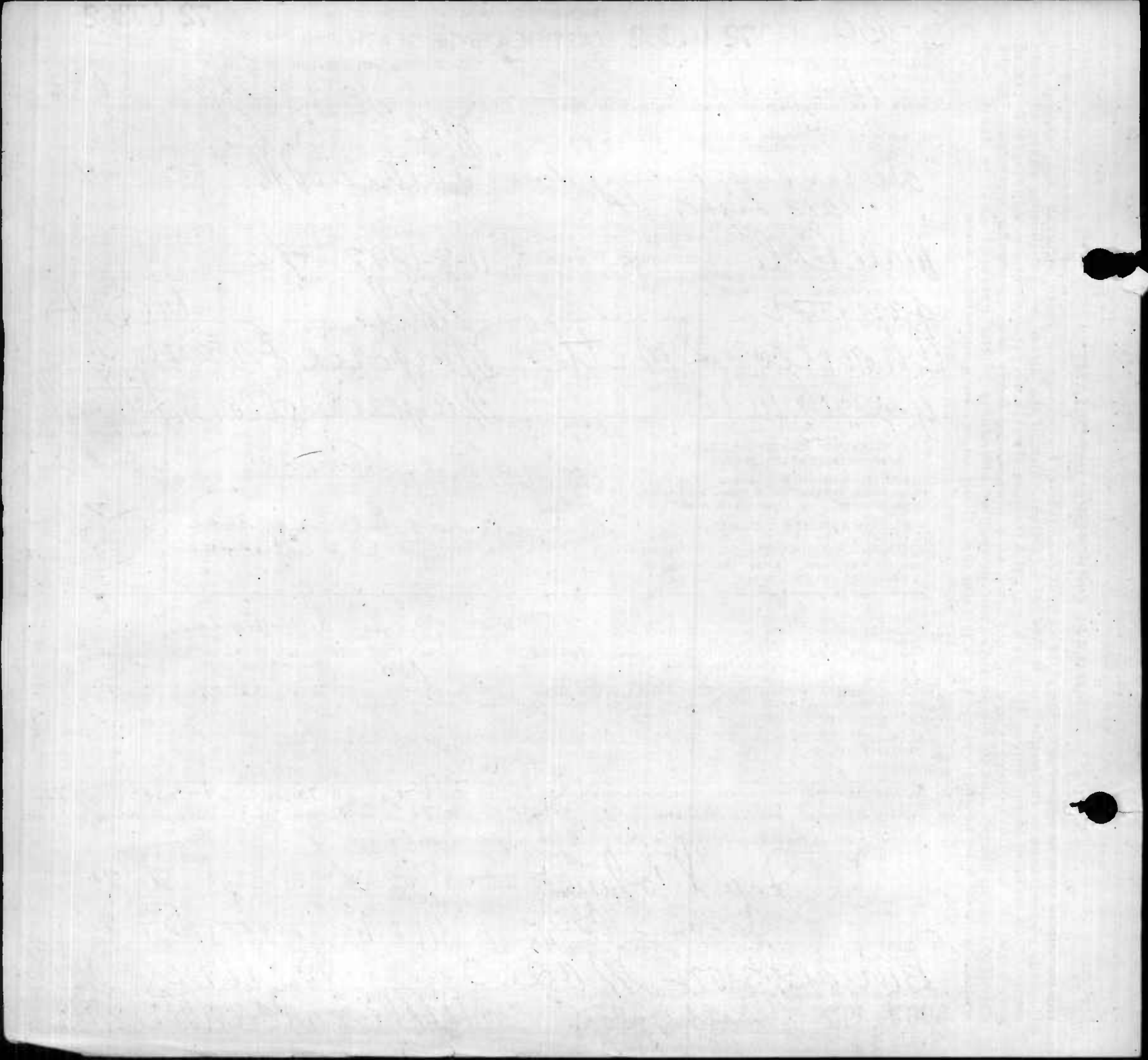
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| S-530 | | 72 07362 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07362 | |
| BIRTH NO. | | 72 07362 | | CERTIFICATE OF DEATH | | REG. NO. STATE OF MARYLAND | |
| 1. NAME OF DECEASED (Type or Print) <u>Henry Smith</u> | | | | 2. DATE AND HOUR OF DEATH <u>July 30 1972</u> <u>6:18 P.</u> M. | | | |
| 3. PLACE IN BALTIMORE MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Harbor View Nursing Home</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 1213 Light St</u> | | A. STATE <u>MD</u> B. COUNTY <u>Calvert</u> | | C. CITY OR TOWN <u>Sethon</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX <u>Male</u> | | 6. RACE <u>Col</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>11-8-1897</u> 9. AGE (In years last birthday) <u>74</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sanitor</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Charles Smith</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mayorie Evans</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes W.W.I</u> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mayorie Sellman</u> ADDRESS <u>Sethon</u> | |
| 18. <u>412.2.1</u> | | | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary Artery</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) <u>Hypertension & Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF <u>C.V. Disease</u> | | ? | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | <u>CVA - Rt. Hemiparesis</u> | | ? | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Feb 21</u> 19 <u>72</u> to <u>July 21</u> 19 <u>72</u> , that (I) (we) lost saw the deceased alive on <u>7-4</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Joseph S. Blum</u> | | | | 23B. DATE SIGNED <u>8/1/72</u> | | 23C. PHYSICIAN'S NAME (Type) <u>JOSEPH S. BLUM</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>8-3-1972</u> | | <u>Moses</u> | | <u>Winters MD</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 3 1972</u> | | 25B. NAME OF REGISTRAR <u>Sidney Horton</u> | | 25C. FUNERAL DIRECTOR <u>William B. ...</u> | | ADDRESS | |



P-400

72 07363 STATE OF MARYLAND-DHMH
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07363

BIRTH NO.

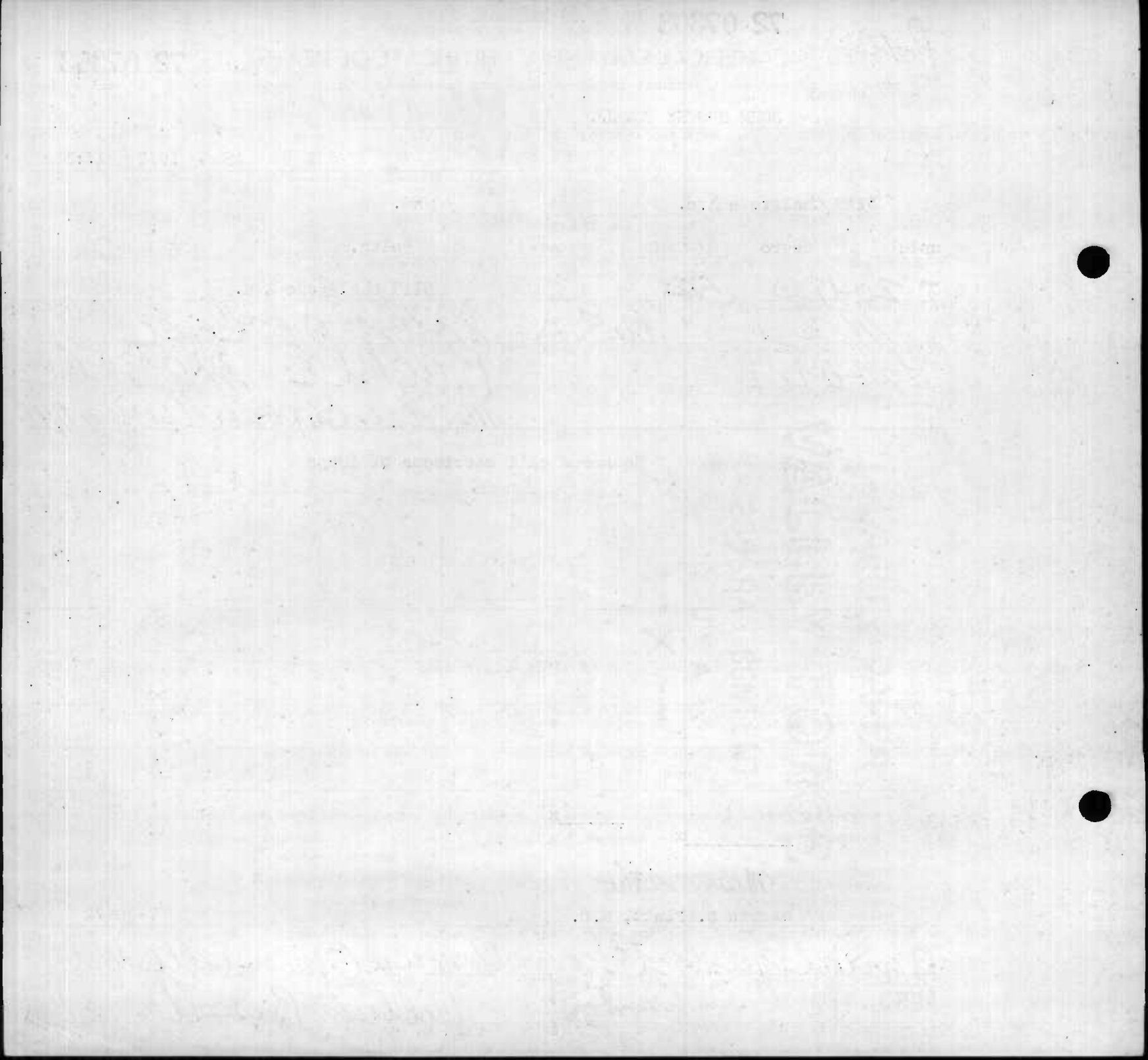
| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) JOHN EUGENE POWELL | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5119 Chalgrove Ave. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 29 1972 11:35a.m. | |
| 6. SEX male | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 7. RACE negro | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 7-20-1930 | | 10. AGE (In years lost birthday) 51 | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 15. MOTHER'S MAIDEN NAME Rachel Makell | | 15. INFORMANT Mildred L. Powell | |
| 15. ADDRESS Anna, Md. | | | |

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| 19. CAUSE OF DEATH 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Squamous cell carcinoma of lungs (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
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|--|--|--|--|--|
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) no |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? |

| | | | | |
|--|--|---|--|--|
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL SIGNATURE Marvin S. Platt | | M.D. | | DATE SIGNED 7-30-72 |
| EXAMINER'S NAME (Type) Marvin S. Platt, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> |
| | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | |

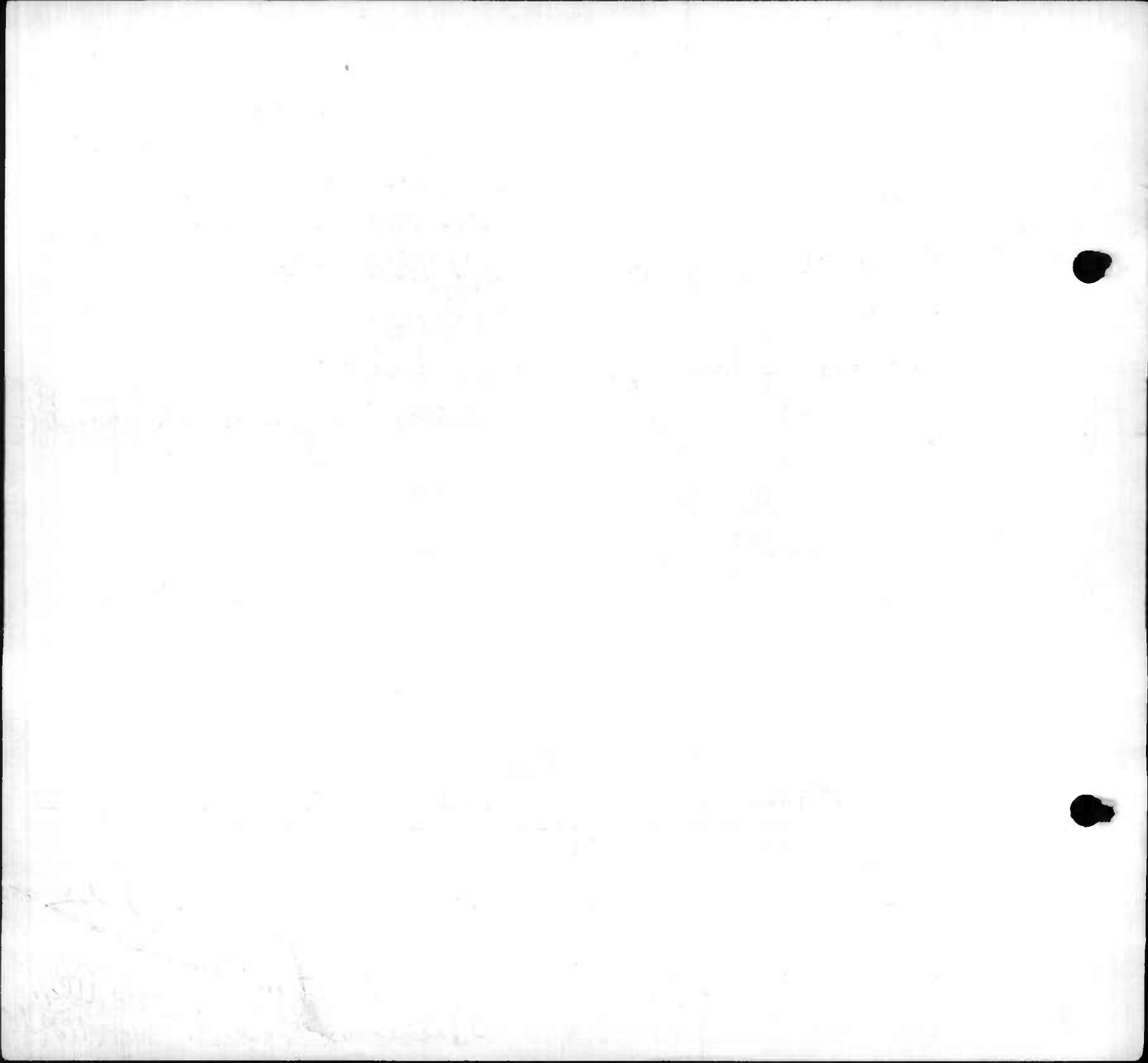
| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-2-1972 | | 24C. NAME OF CEMETERY or CREMATORY Chews Memorial | | 24D. LOCATION (City, town, or county) (State) Owensville Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 3 1972 | | 25B. NAME OF REGISTRAR Sidney Johnston | | 25C. FUNERAL DIRECTOR William Reese | | ADDRESS Anna, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|
| E-363 | | 72 07364 | | BALTIMORE CITY HEALTH DEPARTMENT | | X | | 72 07364 | |
| 72 07364 | | CERTIFICATE OF DEATH | | STATE OF MARYLAND-DHMH | | REG. NO. | | 72 07364 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| Mamie H. Edwards | | 7/31/72 | | 6:20 P.M. | | Md. Prince Arundel 5210 | | C. CITY OR TOWN | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | D. INSIDE CITY LIMITS? | | E. STREET AND NUMBER | | F. STREET AND NUMBER | |
| 38 University of Maryland | | Annapolis | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 212 Choll Drive | | 212 Choll Drive | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | |
| Female | | Col. | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 3/1/1900 | | 72 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTH PLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | |
| Retired | | | | Ala. | | U. S. A. | | John Wesley Holley | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. CAUSE OF DEATH | | 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | |
| No | | | | Gaston Henry Sims - Lanken Rd | | 412-414-2509 | | Congestive heart failure | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| Yes | | | | No | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (1) (this hospital) attended the deceased from | | 23A. SIGNATURE | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 7/31/1972 to 7/31/1972 | | Louis S. Dwyer | |
| 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | |
| 8/1/72 | | | | | | Burial | | 8/6/72 | |
| 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) | | 24E. DATE REC'D BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR | | 24G. FUNERAL DIRECTOR | |
| Mt. Pleasant | | Prestwick Dash. Ala. | | AUG 3 1972 | | William Reese, II - Lanken Rd. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07365 | |
|--|---------|--|--|--|------------------------------|
| <div style="display: flex; justify-content: space-between;"> N-300 72 07365 </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div> | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 2. DATE AND HOUR OF DEATH | |
| LEO | | NEDDO | | July 31, 1972 | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| 40 St. Agnes Hospital | | | | A. STATE Maryland 8. COUNTY 2551 | |
| | | | | C. CITY OR TOWN Baltimore | |
| | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 3373 St. Benedict Street 21229 | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| Male | White | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 12-20-1971 | 70 | U.S.A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Retired Painter | | Self Employed | | Washington, D.C. | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| William Neddo | | | Margaret Hogan | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT |
| NO | | | 214-03-0079 | | ADDRESS 21229 |
| | | | Mrs. Mildred E. Neddo, 3373 St. Benedict St. | | |
| 18. CAUSE OF DEATH | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>ASAD. Old myocardial infarction.</i> (B) <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF: (C) | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>July 11, 1970</i> to <i>July 5, 1972</i> , that (I) (we) last saw the deceased alive on <i>July 5, 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Rafael Perez-Mera</i> | | | | 23B. DATE SIGNED <i>8-1-72</i> | |
| 23C. PHYSICIAN'S NAME (Type) Rafael Perez-Mera | | | | 23D. ADDRESS 8507 Liberty Road, Baltimore, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 8-3-1972 | | New Cathedral Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| AUG 3 1972 | | <i>Sidney H. Hubbard</i> | | Howard H. Hubbard, 4107 Wilkens Ave. 21229 | |
| 24D. LOCATION (City, town, or county) | | 24E. LOCATION (State) | | | |
| Baltimore, Maryland | | | | | |

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BALTIMORE CITY HEALTH DEPARTMENT

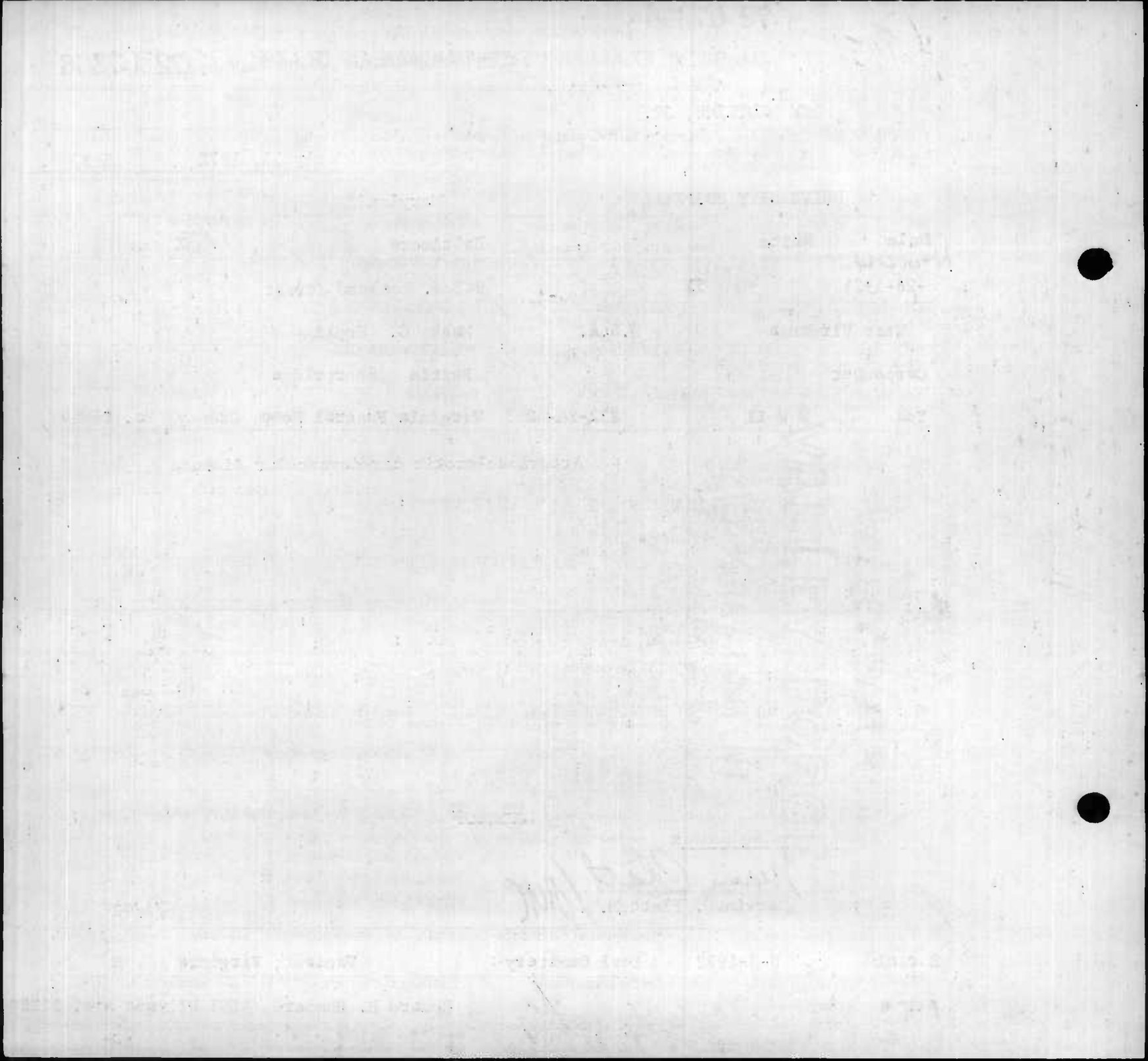
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07366

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) B. MACK HOPKINS, JR. | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL | | 3. DATE PRONOUNCED DEAD Month Day Year Hour July 31, 1972 6:55 P.M. | |
| 6. SEX Male | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 9. DATE OF BIRTH 8-26-1921 | | 10. AGE (In years last birthday) 50 XX | |
| 11. BIRTHPLACE (State or foreign country) West Virginia | | 12. CITIZEN OF U.S.A. | |
| 13. FATHER'S NAME Mack C. Hopkins | | 14. MOTHER'S MAIDEN NAME Hettie Shortridge | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W II | | 17. SOCIAL SECURITY NO. 232-20-4265 | |
| 18. INFORMANT Virginia Funeral Home, Grundy, Va. 24614 | | ADDRESS | |
| 19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22D. TIME (Month) (Day) (Year) (Hour) (Approx.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Marvin Platt EXAMINER'S NAME (Type) Marvin S. Platt, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/1/72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-3-1972 | |
| 24C. NAME of CEMETERY or CREMATORY Beel Cemetery | | 24D. LOCATION (City, town, or county) (State) Vansant, Virginia | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 3 1972 | | 25B. NAME OF REGISTRAR Sidney Whorton | |
| 25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | ADDRESS | |

1 9 7 2 0 0 0 3 3 6 2



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|--------------------------|---|--|--|--|---|--|--|--|
| M-230 | | 72 07367 | | CERTIFICATE OF DEATH | | X | | REG. NO. 72 07367 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) MACATEE, JAMES EDWARD SR. | | | | 2. DATE AND HOUR OF DEATH JULY 31 1972 2:30P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 5.3.00 | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL CATON & WILKENS AVENUE BALTIMORE MARYLAND 21229 | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | E. STREET AND NUMBER 209 OAKLEE VILLAGE 21229 | | 9. AGE (In years last birthday) 89 | | 10. Under 1 Yr. Months: Days: Hours: Min. | |
| 5. SEX MALE | 6. RACE CAUCASIAN | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 08 26 82 | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICE WORKER | | 10B. KIND OF BUSINESS OR INDUSTRY AUCTIONEER | | 13. FATHER'S NAME FRANK MACATEE | | 14. MOTHER'S MAIDEN NAME MARY L. GLENN MACATEE | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. 213 01 1734 | | 17. INFORMANT WILKENS AVENUE BALTO MD 21229 | | ADDRESS ST. AGNES HOSPITAL RECORDS CATON & | | 18. 250.91 | | CAUSE OF DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | ANTECEDENT CAUSES | | DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that X (this hospital) attended the deceased from MARCH JULY 20 1972 to JULY 31 1972 , that X (we) last saw the deceased alive on JULY 31 1972 and that in my XX (our) opinion death occurred on the date and hour and from the causes stated above. (X (We) (did) (dXXX) view the body after death. | | 23A. SIGNATURE Donald T. Sai | | 23B. DATE SIGNED 07 31 72 | | 23C. PHYSICIAN'S NAME (Type) DONALD TSAI | |
| 23D. ADDRESS CATON & WILKENS AVENUE 21229 | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-3-1972 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 3 1972 | | 25B. NAME OF REGISTRAR Sidney Johnston | | 25C. FUNERAL DIRECTOR Howard H. Hubbard | | ADDRESS 4107 Wilkens Ave. 21229 | | | |

3-17

RECEIVED MAY 20 1965

CHARTER

ST. AGNES HOSPITAL
CATHY S. WILKINS AND
SILVIA S. WILKINS

100 DAVENPORT AVENUE

APR 20 1965

CHARTER

U.S.A.

RECEIVED

MARY J. GLENN MORTIMER

ST. AGNES HOSPITAL

100 DAVENPORT AVENUE
CATHY S. WILKINS AND
SILVIA S. WILKINS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

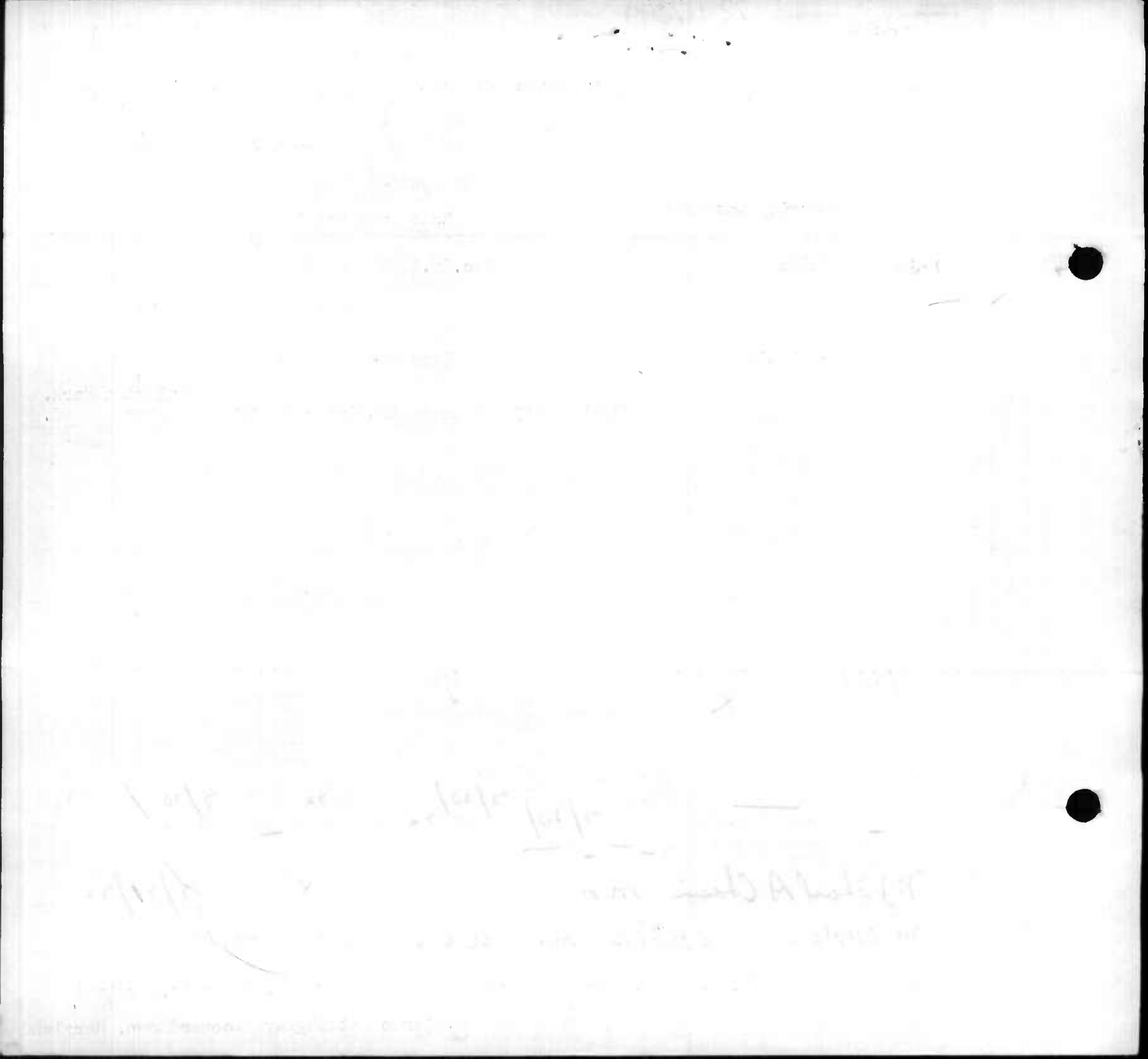
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | REG. NO. 72 07368 STATE OF MARYLAND - DUMB |
|--|---------------------------|--|-------------------------------------|--|
| BIRTH NO. E-360 | | 72 07368 | | |
| 1. NAME OF DECEASED (Type or Print) LUDWIG EDER | | 2. DATE AND HOUR OF DEATH 31 July 1972 9:54 PM M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2731 C. CITY OR TOWN Baltimore 21206 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4222 Diller Avenue | | |
| 5. SEX Male | 6. RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 16 Aug 1897 | 9. AGE (In years last birthday) 74 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) longshoreman | | 10B. KIND OF BUSINESS OR INDUSTRY maritime | | 11. BIRTHPLACE (State or foreign country) Germany |
| 13. FATHER'S NAME Joseph Eder | | 14. MOTHER'S MAIDEN NAME unobtainable | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 744-16-7532 | | 17. INFORMANT ADDRESS Mrs. Anna Braml, 4222 Diller Ave. 21206 |
| 18. 410.9 + 019.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: (B) generalized arteriosclerosis years (C) Emphysema - COPD - 10+ years Old TBC (inactive) 20 yrs. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH — |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 1960's 19 to Jul 19 72 19, that (I) (we) last saw the deceased alive on mid Jul 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE Edmund S. Beacham M.D. | | 23B. DATE SIGNED 1 Aug 72 | | |
| 23C. PHYSICIAN'S NAME (Type) E. G. BEACHAM M.D. | | 23D. ADDRESS Baltimore City Hospitals | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | 24B. DATE 4 Aug 72 | 24C. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. 21206 |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 3 1972 | | 25B. NAME OF REGISTRAR Anthony J. ... | | 25C. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home, Balto., Md. 21206 |

100

WALL

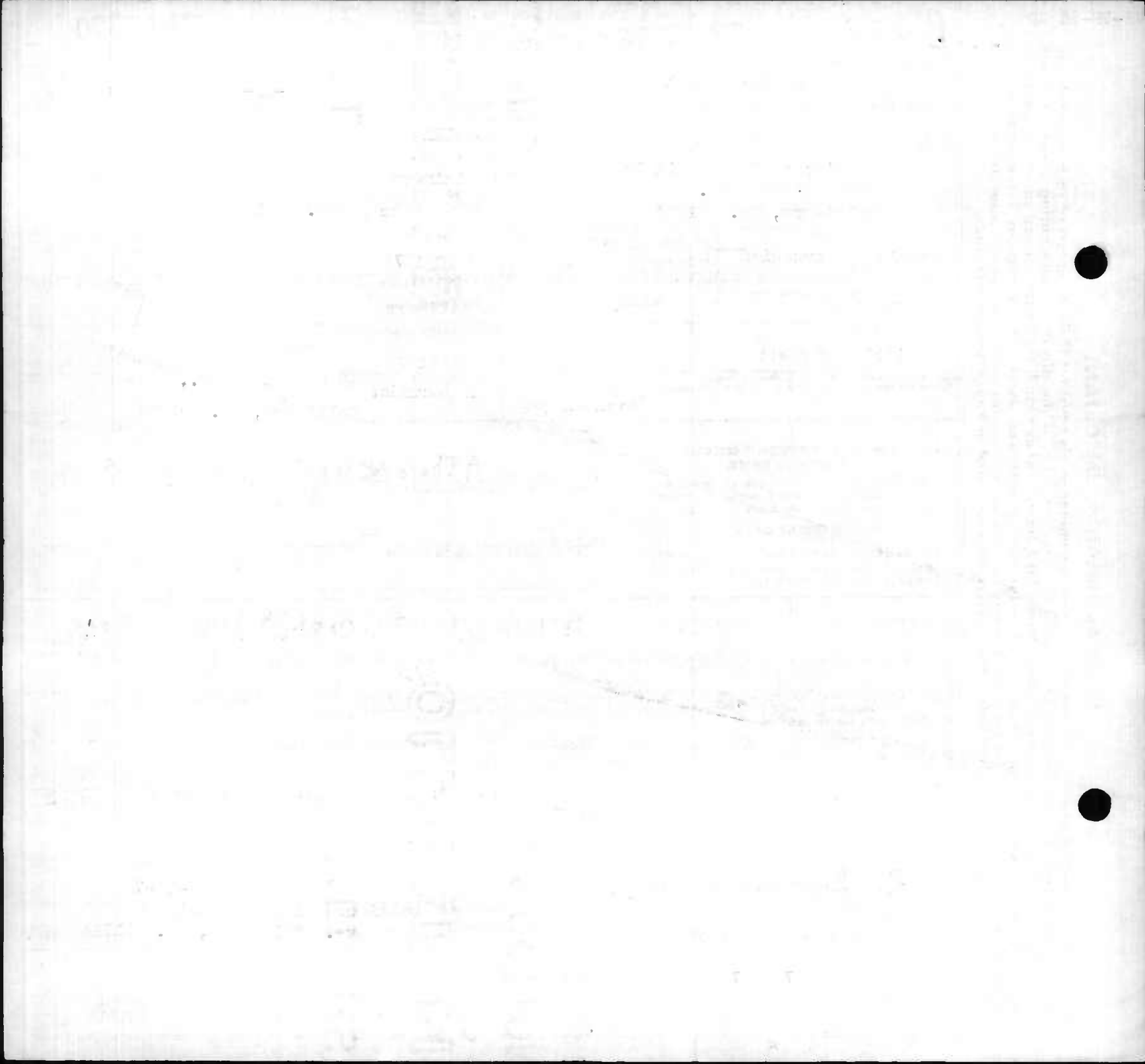
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-632 72 07369 BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07369 | |
|---|----------------------------------|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | |
| STATE OF MARYLAND-DEATH | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) LEONARD BIRTWISTLE | | 2. DATE AND HOUR OF DEATH 7/30/72 | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 38 University Hospital | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY St Mary's | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital | | | C. CITY OR TOWN Hollywood D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| E. STREET AND NUMBER Half Pone Point | | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 26, 1946 | 9. AGE (in years last birthday) 25 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? US |
| 13. FATHER'S NAME Roy Birtwistle | | | 14. MOTHER'S MAIDEN NAME Elizabeth May Snively | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215 44 4153 | 17. INFORMANT Jo Anne Birtwistle ADDRESS Lexington Park, Md. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH EX 16-10 This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death. Craniocerebral Injuries ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Blunt force trauma (B) Automobile accident DUE TO, OR AS A CONSEQUENCE OF: (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 7/30/72 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Subdural Hematoma | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Road | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Patuxent River Rd 58-00 | |
| 21D. TIME OF INJURY (APPROX.) 7-30-72 12:55 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? driver of auto that ran off road & struck left side of car | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/30/72 to 7/30/72 and that (I) (we) last saw the deceased alive on 7/30/72 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Michael A Chasin M.D. | | | 23B. DATE SIGNED 7/30/72 | | |
| 23C. PHYSICIAN'S NAME (Type) MICHAEL CHASIN M.D. | | | 23D. ADDRESS UNIV MD HOSP | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE Aug. 3, 1972 | 24C. NAME OF CEMETERY OR CREMATORY Joy Chapel Cemetery | | 24D. LOCATION (City, town, or county) (State) Hollywood, St Mary's, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 3 1972 | | 25B. NAME OF REGISTRAR W. Clarke Mattingley | | 25C. FUNERAL DIRECTOR ADDRESS Leonardtwn, Maryland | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

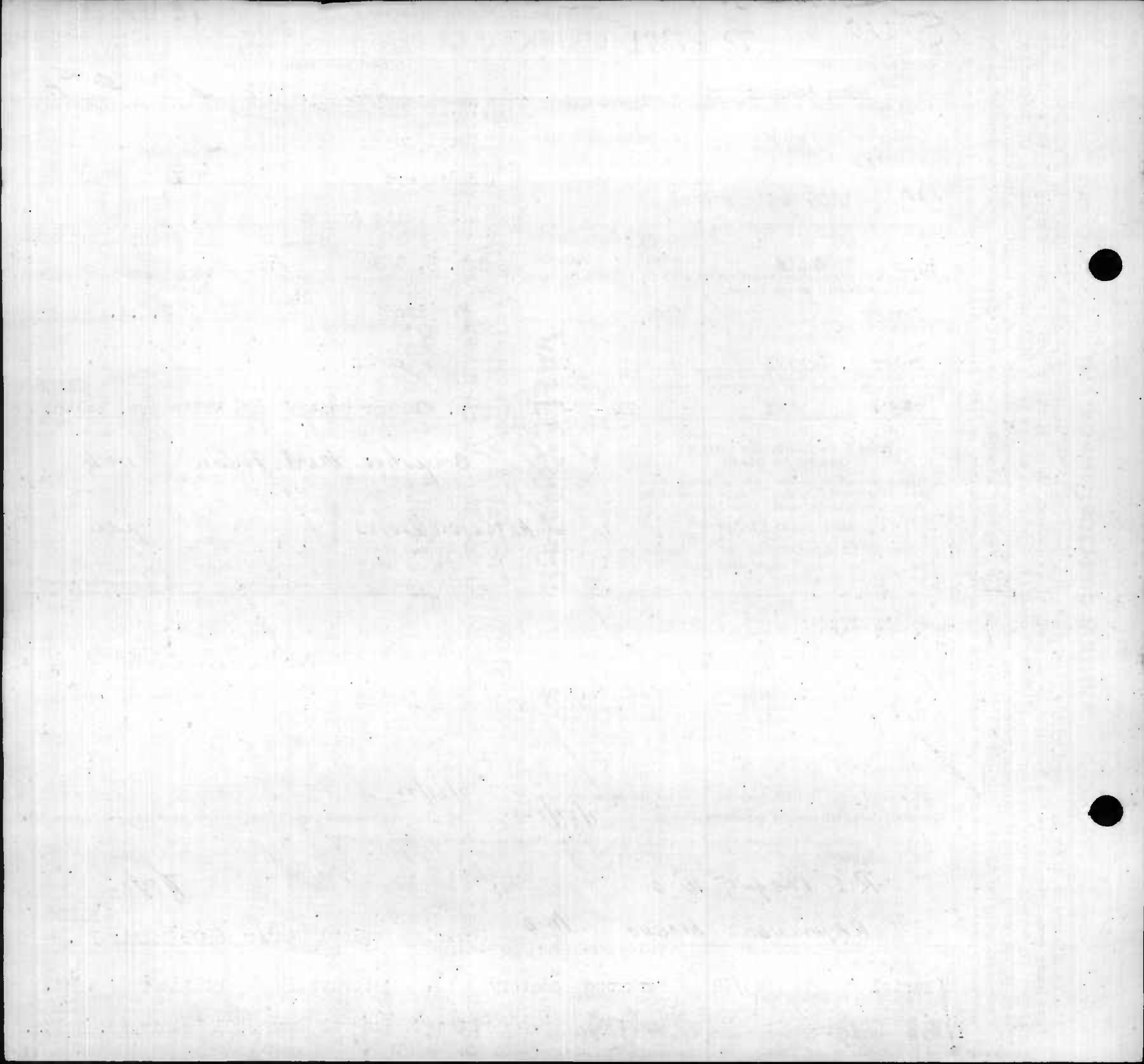
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07370 | |
|---|---|---|---|--|--|
| B-630 72 07370 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | | | STATE OF MARYLAND-DHMH | |
| 1. NAME OF DECEASED (Type or Print) Katherine Barrett | | | 2. DATE AND HOUR OF DEATH 7-15-72 9:30 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224 | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2612 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4940 Eastern Ave. 21224 | | |
| 5. SEX Female | 6. RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-20-1871 | 9. AGE (in years last birthday) 100 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10B. KIND OF BUSINESS OR INDUSTRY home | 11. BIRTHPLACE (State or foreign country) Baltimore | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME William Barrett | | | 14. MOTHER'S MAIDEN NAME Janet ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 212-26-2766 | 17. INFORMANT BCH Records: 4940 Eastern Ave., ADDRESS Baltimore, Md. 21224 | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 Yrs. Atherosclerotic Coronary disease 8 Yrs. Atherosclerotic Cerebral Dis. | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-7-1964 to 7/15/1972 that (I) (we) last saw the deceased alive on 7-15-1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE R. Lanham M.D. | | | 23B. DATE SIGNED 7-15-72 | | 23C. PHYSICIAN'S NAME (Type) R. Lanham |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-31-72 | 24C. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 3 1972 | | 25B. NAME OF REGISTRAR WALTER DABROWSKI | | 25C. FUNERAL DIRECTOR 1005 DUNDALK AVENUE | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

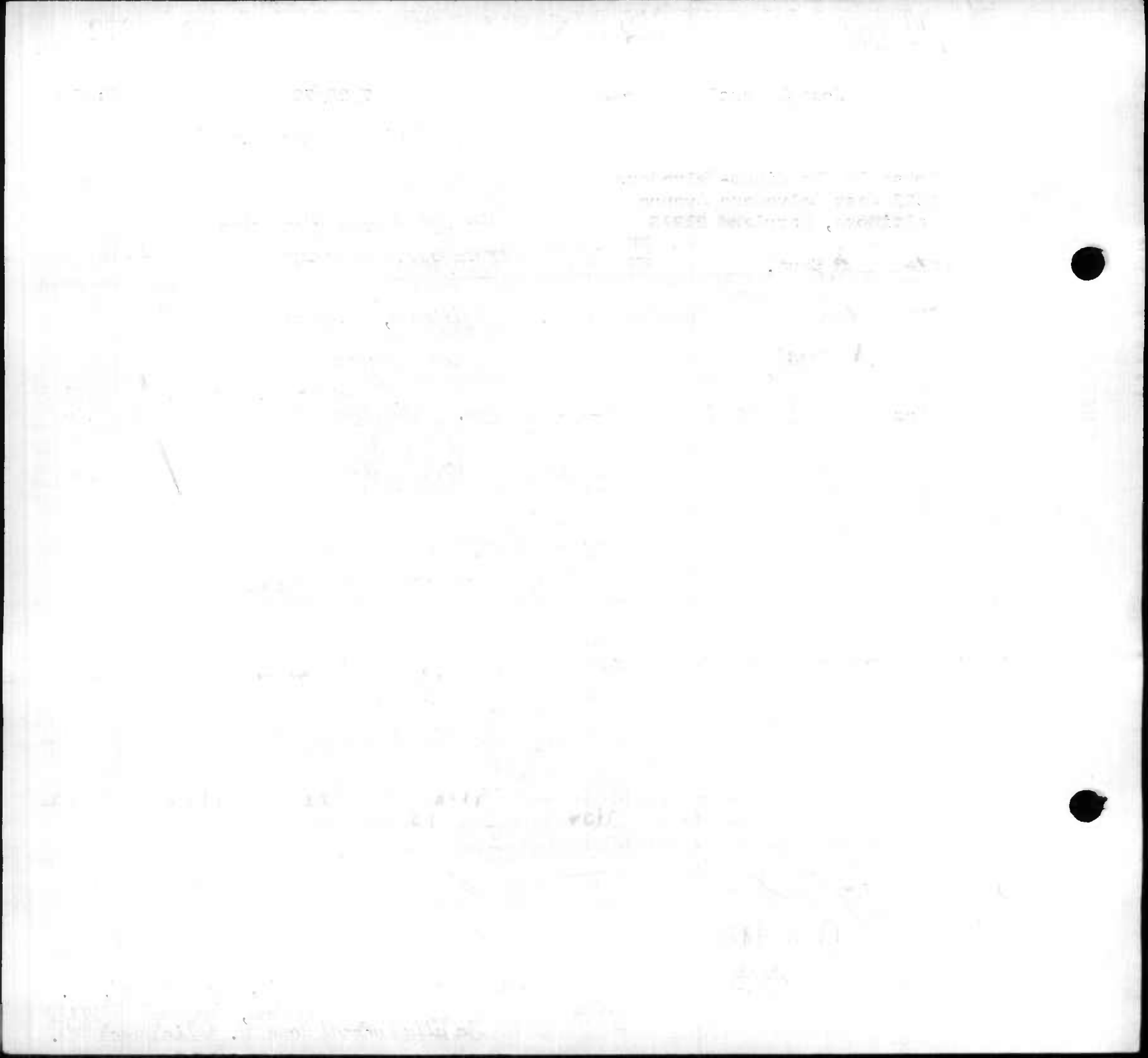
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07371 | | 72 07371 | |
|--|-------------------------|---|---|--|--|---|---|
| BIRTH NO. | | | | 72 07371 | | REG. NO. | |
| STATE OF MARYLAND-DEPT. | | | | 72 07371 | | M. | |
| 1. NAME OF DECEASED (Type or Print) <u>Adam John Scharf</u> | | | | 2. DATE AND HOUR OF DEATH <u>July 31, 1972</u> <u>5:45</u> A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2631</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 4605 White Avenue</u> | | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER <u>4605 White Avenue</u> | | | | | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 5, 1896</u> <u>75</u> | | 9. AGE (In years last birthday) <u>75</u> | | 10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Own</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>Peter J. Scharf</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Rosa Coombs</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u> | | | | 16. SOCIAL SECURITY NO. <u>214-38-7214</u> | | 17. INFORMANT <u>Mrs. Eleanor Scharf</u> | |
| | | | | ADDRESS <u>21206</u> | | | |
| 18. <u>440.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CONGESTIVE HEART FAILURE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ARTERIOSCLEROSIS</u> | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>1 wk</u> | | (B) DUE TO, OR AS A CONSEQUENCE OF: <u>years</u> | |
| (C)..... | | | | | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7/27/72</u> 19 to <u>7/27/72</u> 19, that (I) (we) last saw the deceased alive on <u>7/27/72</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>R-S. MAGNO, M.D.</u> | | | | 23B. DATE SIGNED <u>8/31/72</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>RAYMONDO MAGNO M.D.</u> | | | | 23D. ADDRESS <u>Overlea Medical Center 6801 Belair Rd.</u> | | 21206 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>8/3/72</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Parkwood Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Parkville Baltimore Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>1UG3 1972</u> | | | | 25B. NAME OF REGISTRAR <u>Anthony [Signature]</u> | | 25C. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7401 Belair Rd. Balto.</u> | |
| | | | | ADDRESS <u>21236</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

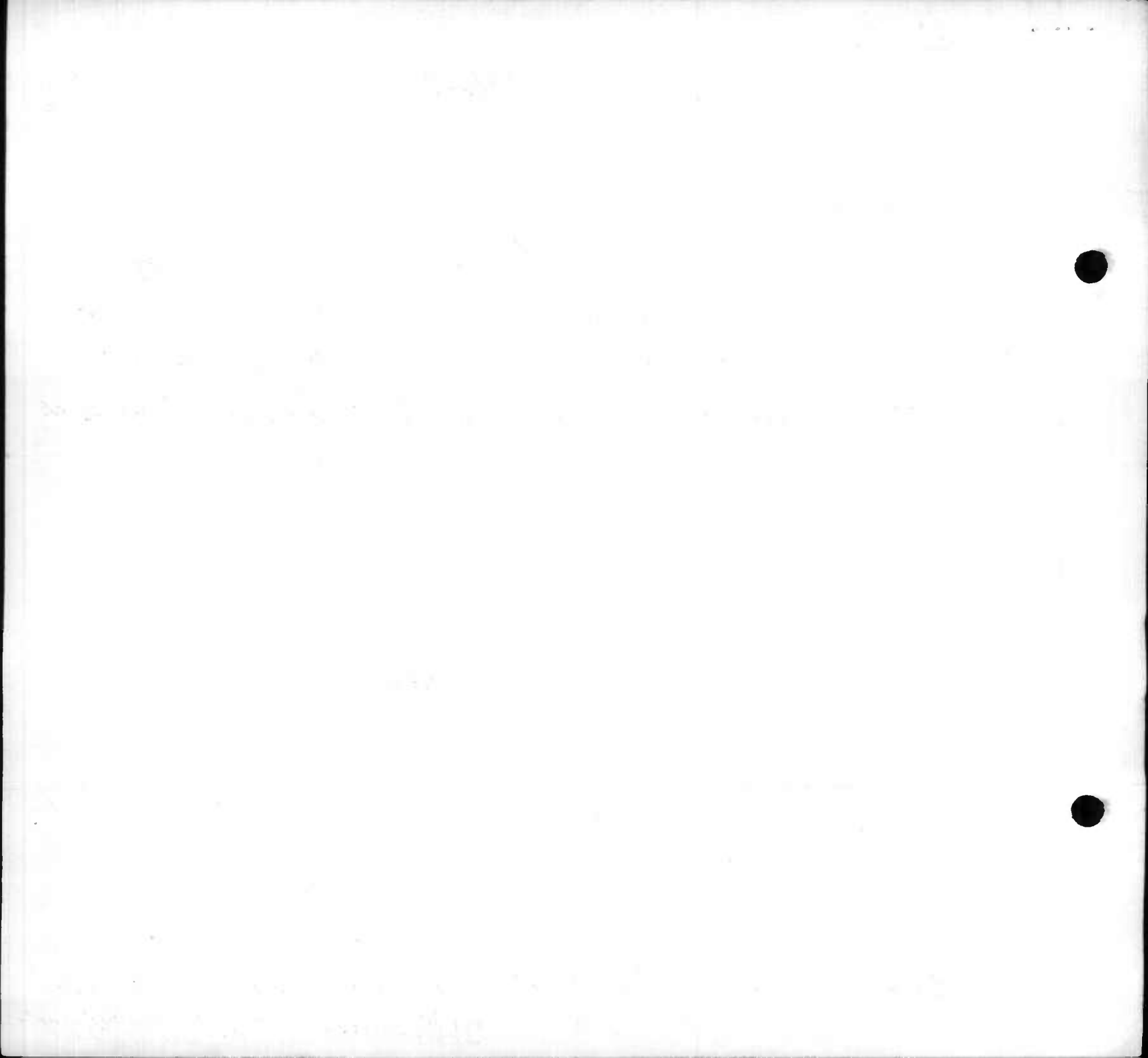
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07372 | | REG. NO. 72 07372 | |
|---|--|---|--|--|--|--|--|
| M-624 | | | | 72 07372 | | STATE OF MARYLAND-DEATH | |
| 1. NAME OF DECEASED (Type or Print) Joseph Mercl (Metzel) | | | | 2. DATE AND HOUR OF DEATH 7/28/72 5:45 a.m. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) House In The Pines-Belvedere 2525 West Belvedere Avenue Baltimore, Maryland 21215 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Anne Arundel 5200 | | | |
| 5. SEX Male 6. RACE XX Cauca. 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH 3/10/1894 | | 9. AGE (In years last birthday) 78 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yard Foreman | | | | 10B. KIND OF BUSINESS OR INDUSTRY Maryland Car Co. | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME Joseph Mercl | | | |
| 14. MOTHER'S MAIDEN NAME Mary Tomacer | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War 1 | | | |
| 16. SOCIAL SECURITY NO. 216-07-1692 | | | | 17. INFORMANT ADDRESS Pasadena, Maryland 21122 Mrs. Edith Fine Box 299 Forest Glen Drive | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 492X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Syphemia Submerged Arteriosclerosis | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days - ? | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/10 19 72 to 7/28 19 72 that (I) (we) last saw the deceased alive on 7/28 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Dr. H. A. Kochman | | | | 23B. DATE SIGNED 7-28-72 | | 23C. PHYSICIAN'S NAME (Type) Dr. H. A. Kochman | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/1/72 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Park | | 24D. LOCATION (City, town, or county) (State) Glen Burnie, Anne Arundel, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 3 1972 | | 25B. NAME OF REGISTRAR Dorothy Johnson | | 25C. FUNERAL DIRECTOR ADDRESS Pasadena, Maryland 21122 McCully Funeral Home Mt. & Tick Neck Rds. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07373 |
|--|--|--|--|--|
| G-620 72 07373 CERTIFICATE OF DEATH | | | | STATE OF MARYLAND-DEME |
| BIRTH NO. 72-11028 | | 1. NAME OF DECEASED (Type or Print) GROSS, PATRICK Michael | | |
| 2. DATE AND HOUR OF DEATH | | 7/31/72 3:25 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | | |
| UNIVERSITY HOSP. OF MARYLAND | | MARYLAND - BALTO 5200 | | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> |
| MALE | | CAUCASIAN | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| 7/2/72 | | 29 | | BABY |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME |
| BALTIMORE - MD | | U.S.A. | | EDWARD J. GROSS Jr. |
| 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. |
| MARILYN E. Patrick | | No | | None |
| 17. INFORMANT | | 18. CAUSE OF DEATH | | 19. MEDICAL CERTIFICATION |
| M/Edw J. Gross Jr. | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |
| ADDRESS | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| Sampas 4 | | DISSEMINATED INTRAVASCULAR | | |
| | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: COAGULATION | | |
| | | (B) SEPSIS DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | (C) | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 2 | | | | YES |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/30/72 to 7/31/72 that (I) (we) last saw the deceased alive on 7/31/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) |
| M. D. | | 7/31/72 | | MATESIC |
| 23D. ADDRESS | | 23E. ADDRESS | | 23F. ADDRESS |
| UNIV. HOSP. OF MARYLAND | | UNIV. HOSP. OF MARYLAND | | UNIV. HOSP. OF MARYLAND |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY |
| Burial | | 8/3/72 | | Cedar Grove Cemetery |
| 24D. LOCATION (City, town, or county) | | 24E. LOCATION (City, town, or county) | | 24F. LOCATION (City, town, or county) |
| Glen Burnie | | Glen Burnie | | A.A. Trul. |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR |
| AUG 3 1972 | | Dorothy H. Heston | | Samuel H. Heston |
| 25D. ADDRESS | | 25E. ADDRESS | | 25F. ADDRESS |
| Glen Burnie, Md. | | Glen Burnie, Md. | | Glen Burnie, Md. |



61-58-78

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| W-300 | | 72 07374 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07374 | |
|--|-----------------------------|---|--|--|--|---|-----------------------|
| BIRTH NO. | | 72 07374 | | REG. NO. | | STATE OF MARYLAND-DHMH | |
| 1. NAME OF DECEASED (Type or Print) <u>WOODFORD WHITE</u> | | | | 2. DATE AND HOUR OF DEATH <u>7/31/72</u> <u>12 40</u> <u>PM</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>702</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospital</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>4940 Eastern Avenue, Baltimore, Md 21224</u> | | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER <u>510 N. Lakewood Ave.</u> | | | | F. <u>702</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>Caucasian</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 1, 1909</u> | 9. AGE (In years last birthday) <u>62</u> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Schluderberg Kurlde</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Maurice R. White</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Fannie Elizabeth Jane Ross</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>WW 2</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>4940 Eastern Avenue</u> <u>BCH Records</u> <u>Baltimore, Maryland 21224</u> | | | |
| 18. <u>7/30/72</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Acute myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Atherosclerotic Coronary Artery Disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Pneumonia</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>24 hours</u> <u>Unknown</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) <u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7/30</u> 19 <u>72</u> to <u>7/31</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>7/31</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Linda Markley</u> DEGREE <u>no</u> | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>7/31/72</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>LINDA MARKLEY</u> DEGREE <u>no</u> | | | | 23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>8/4/72</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Moreland Mem.</u> | | 24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 3 1972</u> | | | | 25B. NAME OF REGISTRAR <u>Leonard J. Ruck Inc.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Balto. Md.</u> | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07375 | |
|---|-------------------------|---|---|--|--|
| G-410 72 07375 | | | | STATE OF MARYLAND - DEPT. OF HEALTH | |
| BIRTH NO. | | | | DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) HOWARD GALLOP | | | | 2. DATE AND HOUR OF DEATH July 31, 1972 | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3122 Weaver Ave. | | | | A. STATE Maryland B. COUNTY 2731 | |
| | | | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 3122 Weaver Ave. | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-7-95 | 9. AGE (In years last birthday) 77 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Salesman | | | 10B. KIND OF BUSINESS OR INDUSTRY Jewelry | | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | 13. FATHER'S NAME John Gallop | | |
| 14. MOTHER'S MAIDEN NAME Henrietta | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. 578-03-0798 | | | 17. INFORMANT ADDRESS Mrs Julia Campbell 3122 Weaver Ave. 21211 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Coronary occlusion (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. None | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). None | | | | | |
| 19A. DATE OF OPERATION NO | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO | | 20A. AUTOPSY? (Yes or No) NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from June 3-7 1972 to July 31 1972 , that (I) (we) last saw the deceased alive on June 3-7 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death. | | | | | |
| 23A. SIGNATURE James E. White MD | | | | 23B. DATE SIGNED July 31, 1972 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. James E. White | | | | 23D. ADDRESS 5214 Harford Rd., Balto. Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-3-72 | | 24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cem. | |
| 24D. LOCATION (City, town, or county) (State) Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT. AUG 3 1972 | | | |
| 25B. NAME OF REGISTRAR Lidney | | 25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc., Balto. Md. 21214 | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|---------------------|--|--|--|--|---|--|
| H-500 | | 72 07376 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07376 | |
| BIRTH NO. | | | | REG. NO. | | | |
| 1. NAME OF DECEASED (Type or Print) HARRY L. HAYNIE | | | | 2. DATE AND HOUR OF DEATH July 31, 1972 12:05 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Univ. of Md. Hospital. | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore City 2734 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Univ. of Md. Hospital. | | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 3804 Hamilton Ave. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12-31-97 | 9. AGE (In years last birthday) 74 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) xxxxxx Virginia | |
| 13. FATHER'S NAME Thomas H. Haynie | | | | 14. MOTHER'S MAIDEN NAME Elva Haynie | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. 219-10-4430 | | 17. INFORMANT T.H. Haynie same | |
| 18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction & shock 2 days ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 2° to Atherosclerotic Cardiovascular Disease | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 2° to Atherosclerotic Cardiovascular Disease (B) Previous DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Uremia 2° to prostatic Obstruction weeks | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that Dr. (this hospital) attended the deceased from 7/28/72 19 72 to 7/31 19 72 that (I) we lost saw the deceased alive on 7/31 19 72 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE [Signature] | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 7/31/72 | |
| 23C. PHYSICIAN'S NAME (Type) A.C. HENNINGSON, M.D. | | | | 23D. ADDRESS 1205 St. Paul St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/2/72 | | 24C. NAME OF CEMETERY or CREMATORY Moreland Mem. | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 3 1972 | | | | 25B. NAME OF REGISTRAR [Signature] | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 72 07377 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 72 07377 |
|---|----------------------|---|---------------------------------------|---|
| 1. NAME OF DECEASED (Type or Print) ROBERT A RICHARDSON | | 2. DATE AND HOUR OF DEATH JULY 28 1972 11:15 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GEN. HOSP. 827 LINDEN AVE. BALTO., MD. 21201 | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY 21207 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3305 FERNDAL AVE. | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JULY 13, 1895 | 9. AGE (In years last birthday) 77 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAB DRIVERS | | 10B. KIND OF BUSINESS OR INDUSTRY DIAMOND CAB | | 11. BIRTHPLACE (State or foreign country) VIRGINIA, RICHMOND |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME EUGENE A RICHARDSON | | |
| 14. MOTHER'S MAIDEN NAME HETTIE ANDERSON | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT LOWRIE RICHARDSON ADDRESS MR. LEON OWEN, - 4406 Botte Rd | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 486 X I | | CAUSE OF DEATH Richmond, VA 23235 | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE Hypertension DUE TO, OR AS A CONSEQUENCE OF: 10 days | | |
| | | (B) Pneumonia; CVA, probably recurrent DUE TO, OR AS A CONSEQUENCE OF: 18 days | | |
| | | (C) ? | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II Myocardial Infarction; DM; Hypertension | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years. | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from July 10 19 72 to July 28 19 72 that (I) (we) last saw the deceased alive on July 28 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | |
| 23A. SIGNATURE Manan; MD | | 23B. DATE SIGNED July 28, 1972 | | 23C. PHYSICIAN'S NAME (Type) R.T. MACIARI, MD. MD |
| 23D. ADDRESS MARYLAND GEN. HOSP. 827 LINDEN AVE., BALTO., MD. 21201 | | 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | |
| 24B. DATE 7-31-72 | | 24C. NAME OF CEMETERY OR CREMATORY Westview Cemetery | | 24D. LOCATION (City, town, or county) (State) Farmville, Virginia |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 3 1972 | | 25B. NAME OF REGISTRAR Andrew Johnson | | 25C. FUNERAL DIRECTOR ARMACOST Funeral Chapel - 4600 Liberty Heights Ave |

A

Eugene A. Richardson

Walter Anderson
Lawrence Richardson

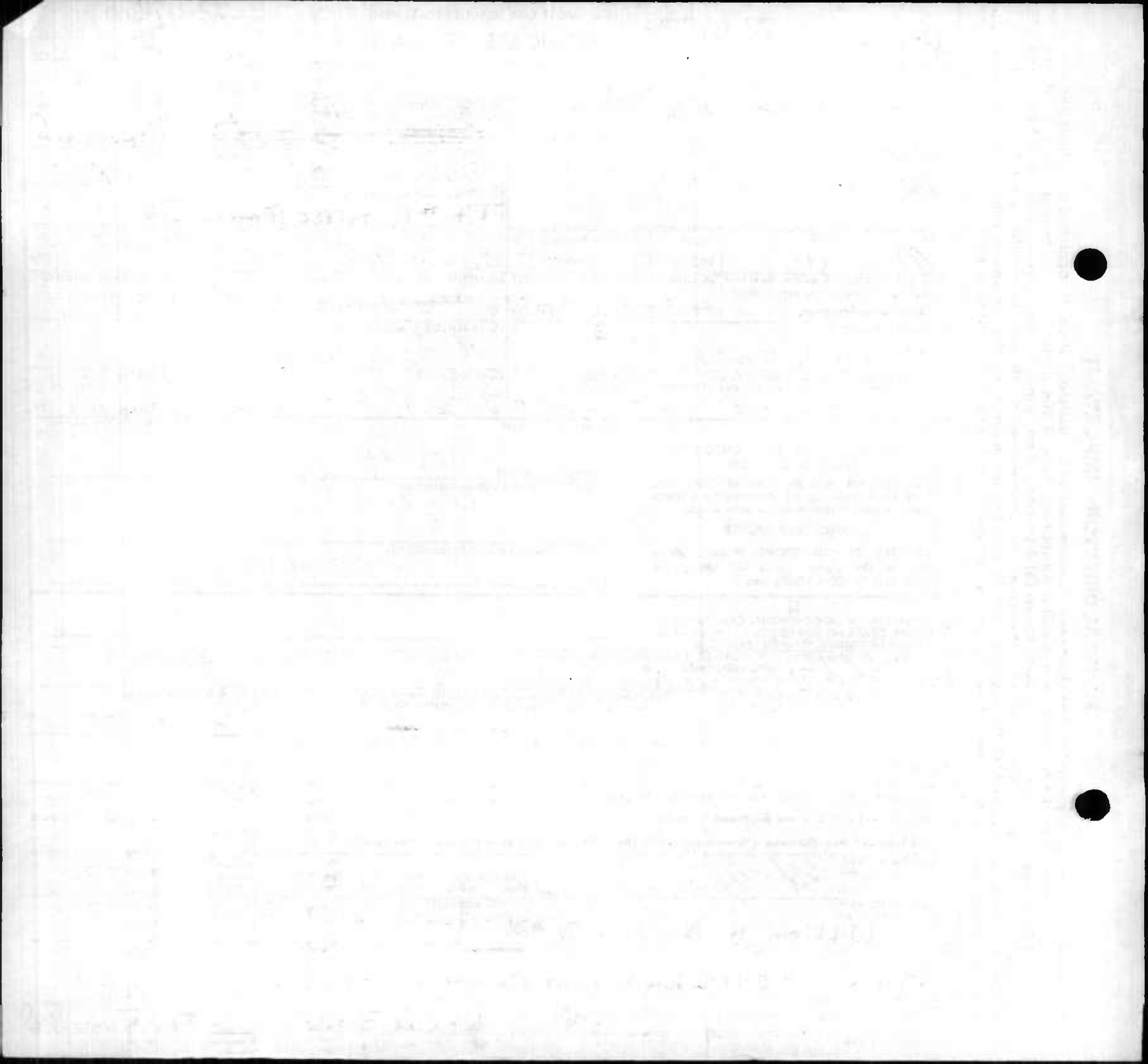
4400 Bette Rd
Richmond, Va 23232

Box 1-31-22 Western Cemetery
Farmville, Virginia

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 72 07378 | | | | DEATH NO. 72 07378 | |
|---|---------------------|---|---|--|-----------------------------|
| D-356 | | | | 72 07378 | |
| BIRTH NO. | | | | DEATH NO. | |
| 1. NAME OF DECEASED (Type or Print) <u>John A. Dettmer Sr.</u> | | | 2. DATE AND HOUR OF DEATH <u>Aug 1, 1972</u> <u>10:32</u> <u>A</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>CARROLL</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u> <u>48</u> | | | C. CITY OR TOWN <u>Finksburg, Md.</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| E. STREET AND NUMBER <u>Rt. #1, Reese Manor Dr.</u> | | | <u>5600</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>16-28-1928</u> <u>47</u> | 9. AGE (In years last birthday) | 10. UNDER 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Contracting Supplies</u> | | |
| 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania, U.S.A</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>Arnon Dettmer</u> | | | 14. MOTHER'S MAIDEN NAME <u>Miriam Kline</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>Army 1942-1945</u> | | | 16. SOCIAL SECURITY NO. <u>219-16-4845</u> | | |
| 17. INFORMANT <u>(Brother) Robert E. Dettmer</u> | | | ADDRESS <u>15 Hillside Ave</u> <u>Calverville, Md</u> | | |
| 18. <u>162-1</u> | | | CAUSE OF DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Ca of left upper lobe</u> <u>A lung c metastases.</u> | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Pyrophopneumonia</u> | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| (C) | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>July 25, 1972</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>scalene Node Biopsy</u> | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <u>No</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>72</u> to <u>Aug 1, 1972</u> and that (I) (we) last saw the deceased alive on <u>July 31</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Wm. H. Mosberg Jr.</u> | | | | 23B. DATE SIGNED <u>8-1-72</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>William H. Mosberg Jr. M.D.</u> | | | | 23D. ADDRESS <u>903 Cathedral St, Baltimore 21201</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>8-5-1972</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Sandymount Cemetery</u> | |
| 24D. LOCATION <u>Finksburg</u> | | (City, town, or county) | | (State) <u>Md</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 3 1972</u> | | 25B. NAME OF REGISTRAR <u>Dorothy H. [Signature]</u> | | 25C. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson Inc.</u> | |
| | | | | ADDRESS <u>Towson, Md.</u> | |

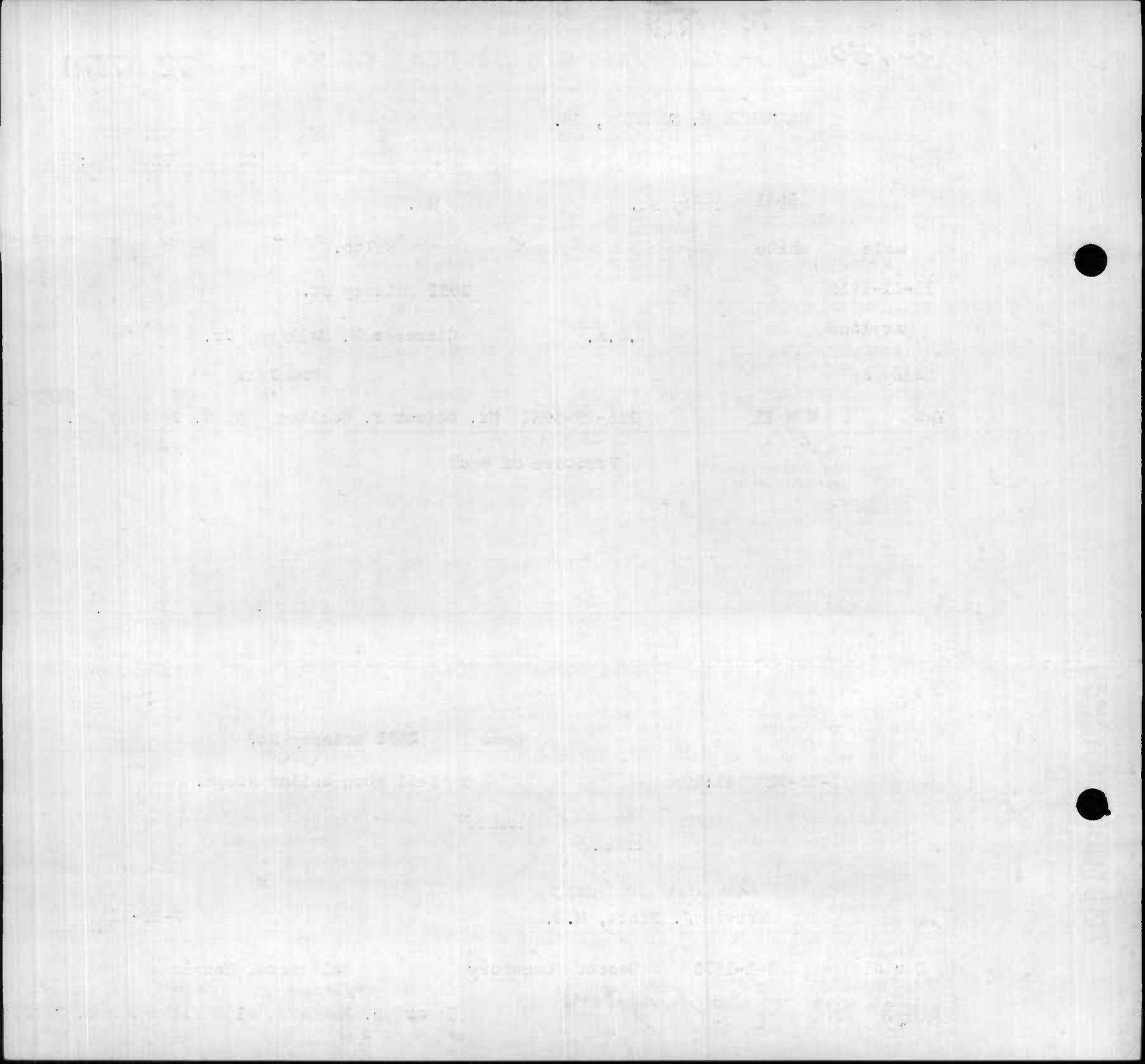


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07379

BIRTH NO.

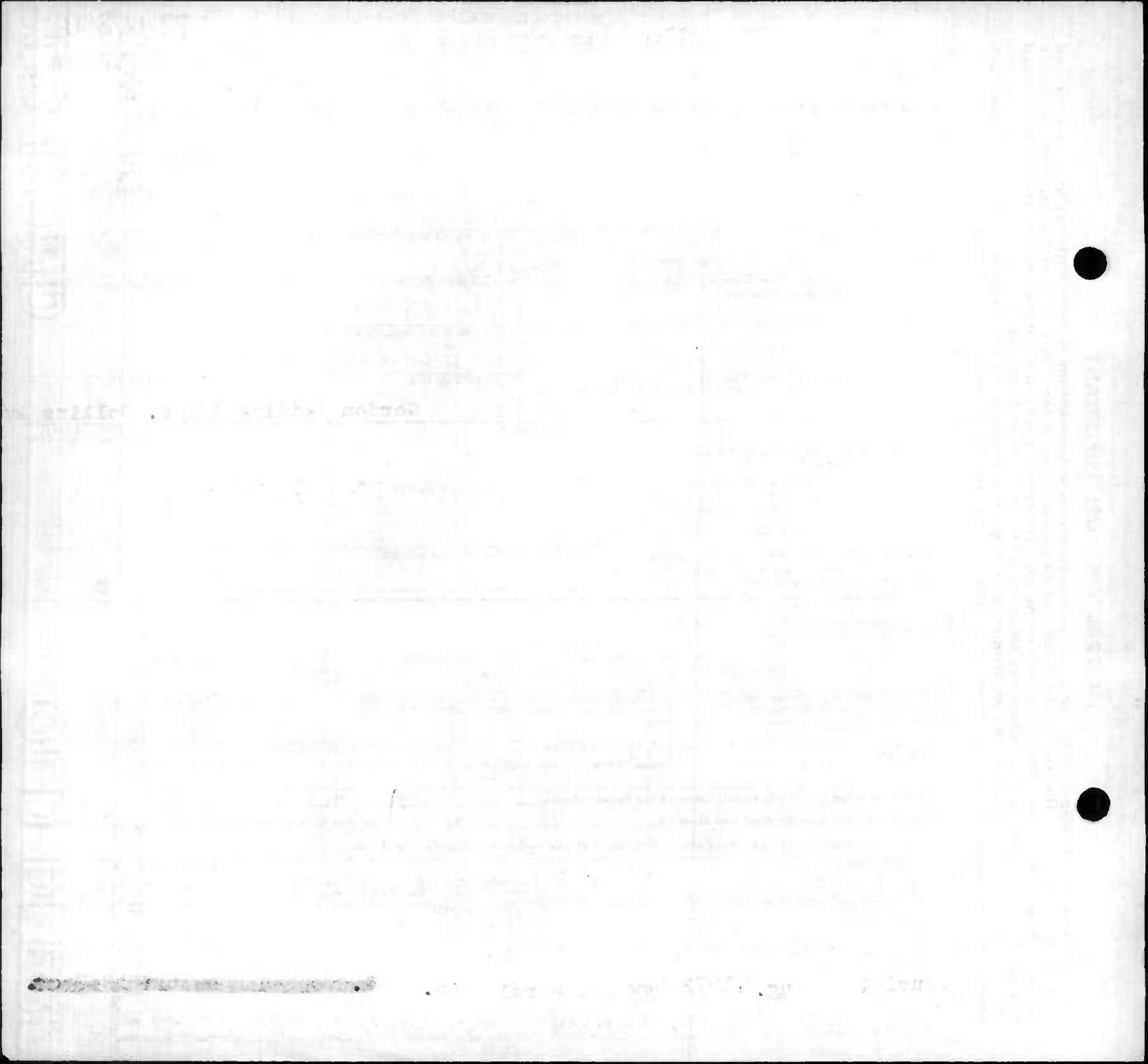
| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) CLARENCE W. GALLION, JR. | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2631 Dulaney St. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 28 1972 11:15 PM | |
| 6. SEX male | | 7. RACE white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 11-11-1915 | | 10. AGE (In years lost birthday) 56 | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) Yes W W 11 | | 17. SOCIAL SECURITY NO. 216-09-5931 | |
| 15. MOTHER'S MAIDEN NAME Mabbitts | | 18. INFORMANT ADDRESS 21223 Mr. Oliver F. Gallion, 400 S. Pulaski St. | |
| 19. E 880X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Fracture of neck ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | CAUSE OF DEATH Fracture of neck (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | |
| 22D. TIME OF INJURY (APPROX.) 7-28-72 11:10p m. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2631 Dulaney St. | | 22F. HOW DID INJURY OCCUR? Fell down cellar steps. | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. DATE SIGNED 7-29-72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-1-1972 | |
| 24C. NAME OF CEMETERY or CREMATORY Western Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 3 1972 | | 25B. NAME OF REGISTRAR Howard H. Hubbard | |
| 25C. FUNERAL DIRECTOR Howard H. Hubbard | | ADDRESS 4107 Wilkens Ave. 21229 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) HARRY O. FETTING | | 2. DATE AND HOUR OF DEATH JULY 30 1972 2:30 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 3480N SECOURS HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY BALT. C. CITY OR TOWN BALT. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX M 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8/18/94 9. AGE in years (last birthday) 77 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) MICH. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME AUGUST FETTING | | 14. MOTHER'S MAIDEN NAME ELENOR CASH | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 216-07-0485 | |
| 17. INFORMANT Gordon Fetting | | ADDRESS 105 S. Collins Ave | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory arrest | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: chronic obstructive pulmonary disease & pneumonia | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) _____ | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month Day Year Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Felimon A. Soria | | 23B. DATE SIGNED 7-30-72 | |
| 23C. PHYSICIAN'S NAME (Type) FELIMON A. SORIA | | 23D. ADDRESS BON SECOURS HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Aug 2, 1972 | |
| 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem. | | 24D. LOCATION (City, town, or county) (State) BALTO MD | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 3 1972 | | 25B. NAME OF REGISTRAR Frederick Schwab | |
| 25C. FUNERAL DIRECTOR G. Freeman Schwab | | ADDRESS 3512 Freeo. | |



C-636 1

72 07381

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 07381

BIRTH NO. STATE OF MARYLAND-DHMH

1. NAME OF DECEASED (Type or Print) Carter, Edna 2. DATE AND HOUR OF DEATH 7-24-72 7:28 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY 402

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bolton Hill Nursing Home, 1400 John Street C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES ☒ NO ☐

E. STREET AND NUMBER 760 Redwood St.

5. SEX F 6. RACE Black 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. DATE OF BIRTH 2-8-04 9. AGE (In years last birthday) 68 10. If Under 1 Yr. Months: Days: 11. If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Washington, D.C. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Washington 14. MOTHER'S MAIDEN NAME Lottie Watson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. 214-64-0863 17. INFORMANT Admission Records ADDRESS

18. 412.2.1 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: years

(B) arteriosclerosis generalized DUE TO, OR AS A CONSEQUENCE OF: years

(C) _____

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/24 1972 to 7/24 1972 that (I) (we) last saw the deceased alive on 7/24 1972 and that in (my) (our) opinion death occurred on the date and hour end from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE [Signature] 23B. DATE SIGNED 7/25/72 Attending Phys. ☐ Med. Director ☒ Staff Phys. ☐

23C. PHYSICIAN'S NAME (Type) Dr. [Name] 23D. ADDRESS 2 E READ ST ROOM 2102

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial 24B. DATE 8/3/72 24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem. 24D. LOCATION (City, town or county) (State) Balto. Md.

25A. DATE REC'D BY HEALTH DEPT. AUG 3 1972 25B. NAME OF REGISTRAR Lidney [Name] 25C. FUNERAL DIRECTOR Williams Funeral Home 3117 [Address] ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Letter No. 1

Dear Mr. [illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 72 07382 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07382 | | REG. NO. 4 | |
|--|------------------|--|--|---|--|--|--|---|--|
| C-416 72-10605 | | | | CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) Baby Girl Clapper | | | | 2. DATE AND HOUR OF DEATH 7/24/72 9:35 P.M. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 2534 | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 S. B. G. H. | | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | E. STREET AND NUMBER 40 Talbott St. | | | | | |
| 5. SEX F | 6. RACE C | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7/24/72 | | 9. AGE (In years last birthday) | | 11. BIRTHPLACE (State or foreign country) MD | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? | | 11 Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. 30 | |
| 13. FATHER'S NAME unk. | | | | 14. MOTHER'S MAIDEN NAME Conita Clapper | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| 18. 776-0 I | | | | CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE Neonatal Asphyxia DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) Aspiration DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| | | | | (C) _____ | | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | Prematurity | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (it) (this hospital) attended the deceased from 7/24 19 72 to 7/24 19 72 that (it) (we) last saw the deceased alive on 7/24 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (It) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE James A. Kopper MD | | | | 23B. DATE SIGNED 7/24/72 | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | |
| 23C. PHYSICIAN'S NAME (Type) James A. Kopper MD | | | | 23D. ADDRESS S.B. G. H. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) 1-31-72 | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | ANATOMY BOARD OF MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 3 1972 | | 25B. NAME OF REGISTRAR Indy Johnson | | 25C. FUNERAL DIRECTOR | | UNIVERSITY MEDICAL SCHOOL | | | |
| | | | | | | MORTUARY SERVICE - BCHD | | | |

SECRET

SECRET

[Faint, mostly illegible text covering the main body of the page, possibly a memorandum or report.]

SECRET

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

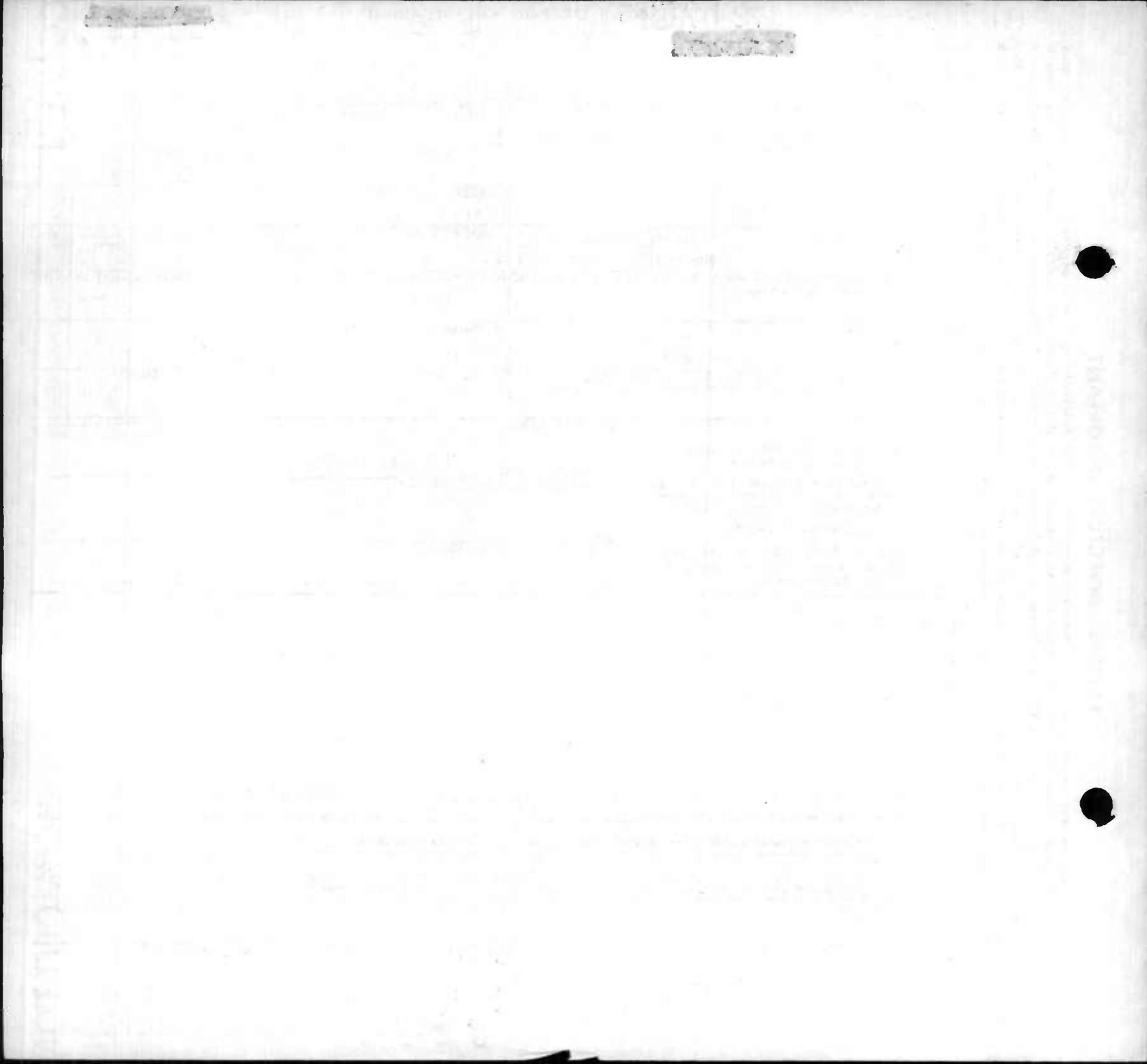
| BIRTH NO. <u>72-10691</u> | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. <u>72 07383</u> STATE OF MARYLAND-DEATH |
|---|-----------------------------|---|------------------------------------|---|
| 1. NAME OF DECEASED (Type or Print) The Baby of Sinclair, Ulene | | 2. DATE AND HOUR OF DEATH July 23, 1972 5:10p. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>39</u> Provident Hospital, Inc. 2600 Liberty Height Ave. Baltimore, Md. 21215 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2405 Elsinore Ave. | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-18-72 | 9. AGE (In years last birthday) 7 18 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME U.S.A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Ulene Sinclair 2405 Elsinore Ave. |
| 18. <u>740X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | CAUSE OF DEATH Anencephaly (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypoplastic Pituitary + (B) DUE TO, OR AS A CONSEQUENCE OF: Adrenal glands. (C) _____ | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from July 18, 1972 to July 23, 1972 , that (I) (we) last saw the deceased alive on July 23, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE Mercado M.D. | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED July 26, 1972 |
| 23C. PHYSICIAN'S NAME (Type) MERCADO M.D. | | 23D. ADDRESS Provident Hospital 2600 Liberty Height Ave. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE 7-31-72 | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town or county) (State) |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 3 1972 | | 25B. NAME OF REGISTRAR Friday, July 27, 1972 | | 25C. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BOND |

50
J. M. J.
R. D. J.
Director of
BECMAN
1880

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

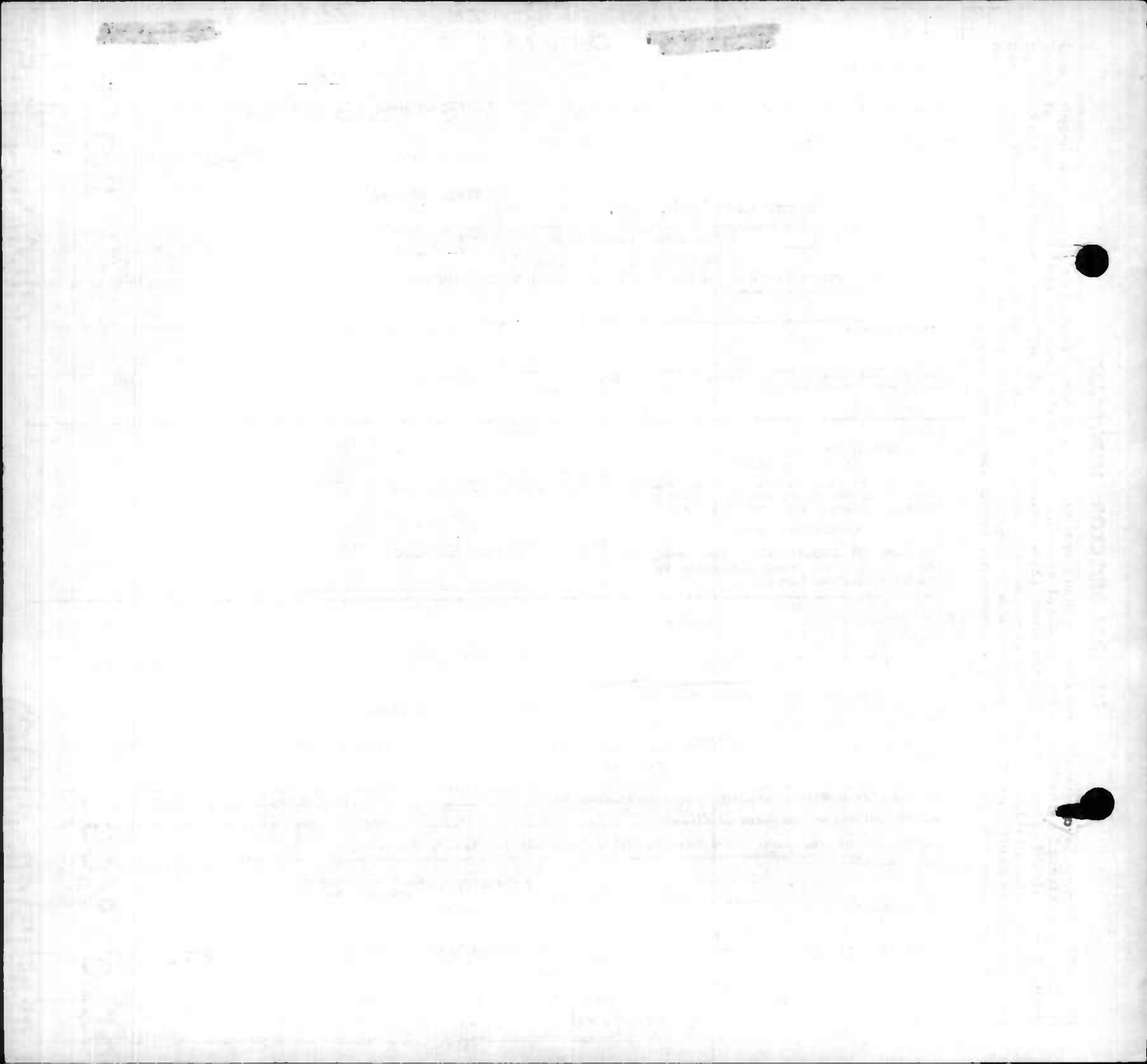
| Baltimore City Health Department | | | | REG. NO. 72 07384 | |
|--|--|---|--|---|--|
| 1-535 72 07384 | | | | 4 | |
| BIRTH NO. 72-10788 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) BABY BOY LINDEMANN | | | 2. DATE AND HOUR OF DEATH JULY 28, 1972 11:40 PM | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | |
| FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTIMORE GENERAL 43 HOSPITAL | | | C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 5. SEX M 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH JULY 28, 1972 9. AGE (In years last birthday) NB | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME HERBERT LINDEMANN | | | 14. MOTHER'S MAIDEN NAME MICHELLE BURY | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT | | | ADDRESS | | |
| 18. 777X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PREMATURITY 24 weeks | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <input type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10pm JULY 28 1972 to 11:40pm JUL 28 1972 that (I) (we) last saw the deceased alive on JULY 28 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Teresta J. Beltram DEGREE | | | 23B. DATE SIGNED July 28, 1972 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS SOUTH BALTIMORE GENERAL HOSP 3001 S. HANOVER BALTO MARYLAND 21230 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 7-31-72 | | 24C. NAME OF CEMETERY or CREMATOR ANATOMY BOARD OF MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 3 1972 | | 25B. NAME OF REGISTRAR Sidney Ingham | | 25C. BUREAU DIRECTOR UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD | |



FUNERAL DIRECTOR: IMPORTANT

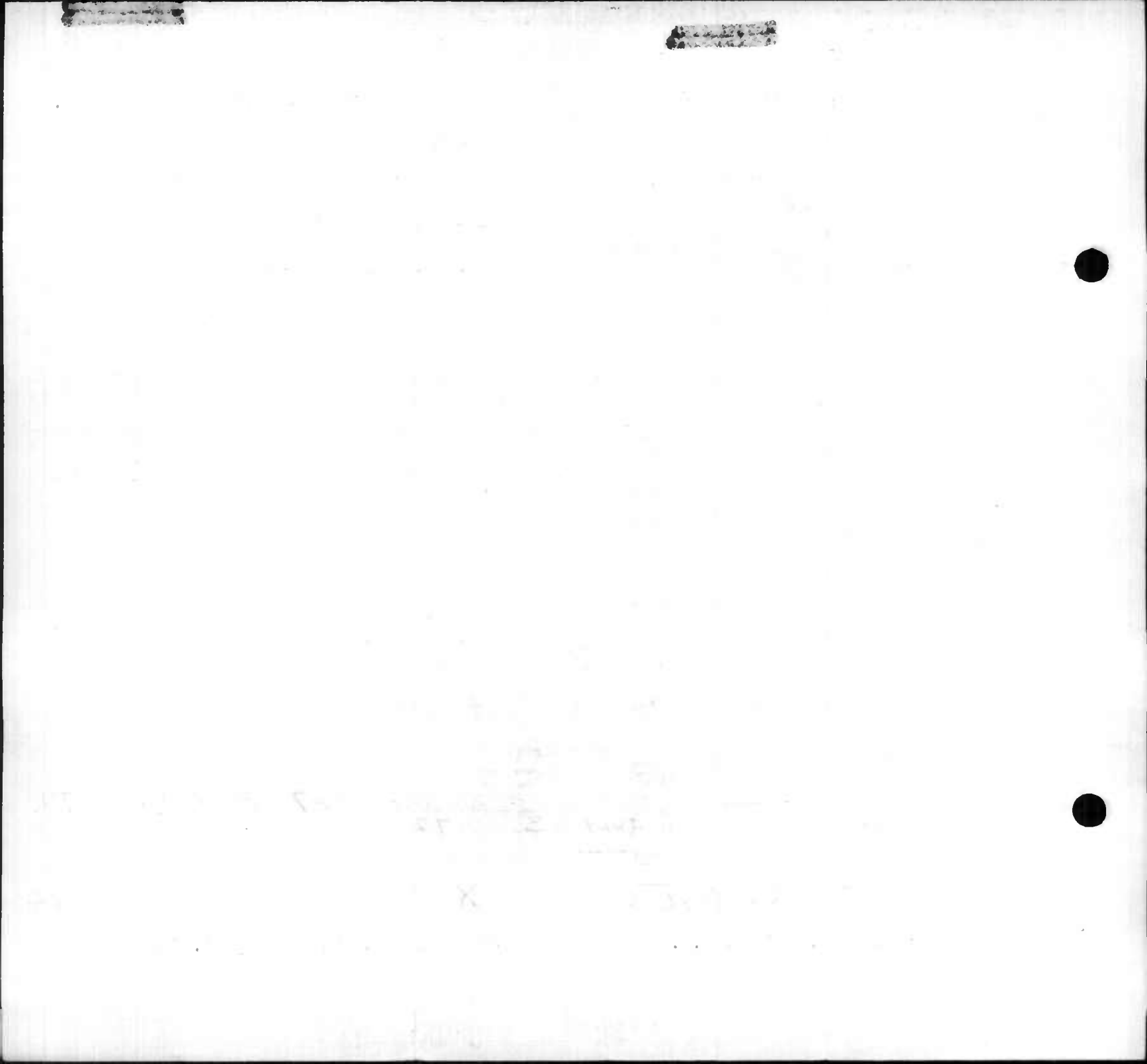
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributory cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 7-652 72 07385 | | BALTIMORE CITY HEALTH DEPARTMENT 72 07385 | | REG. NO. 4 | |
|--|--------------------|---|-----------------------------|--|---|
| BIRTH NO. 72-11471 | | CERTIFICATE OF DEATH | | STATE OF MARYLAND-DHMH | |
| 1. NAME OF DECEASED (Type or Print) Baby Girl Franklin | | 2. DATE AND HOUR OF DEATH 7-22-72 | | 8:45 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital, Inc. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 14 E. Preston St. | | | |
| 5. SEX Female | 6. RACE N negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-15-72 | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME FRANKLIN | | 14. MOTHER'S MAIDEN NAME Pearl Copeland Same | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. 796.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIO-RESPIRATORY ARREST 15 minutes (B) IMMATURITY. DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 7-15 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED UMBILICAL CATH. | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from 7-15 1972 to 7-22 1972 that he (we) last saw the deceased alive on 7-22 1972 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. He (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE E. Macarag | | 23B. DATE SIGNED 7/24/72 | | 23C. PHYSICIAN'S NAME (Type) E. MACARAG MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 7-31-72 | | 24C. NAME OF CEMETERY or CREMATORY ANATOMY BOARD OF MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 3 1972 | | 25B. NAME OF REGISTRAR Sidney Johnson | | 25C. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

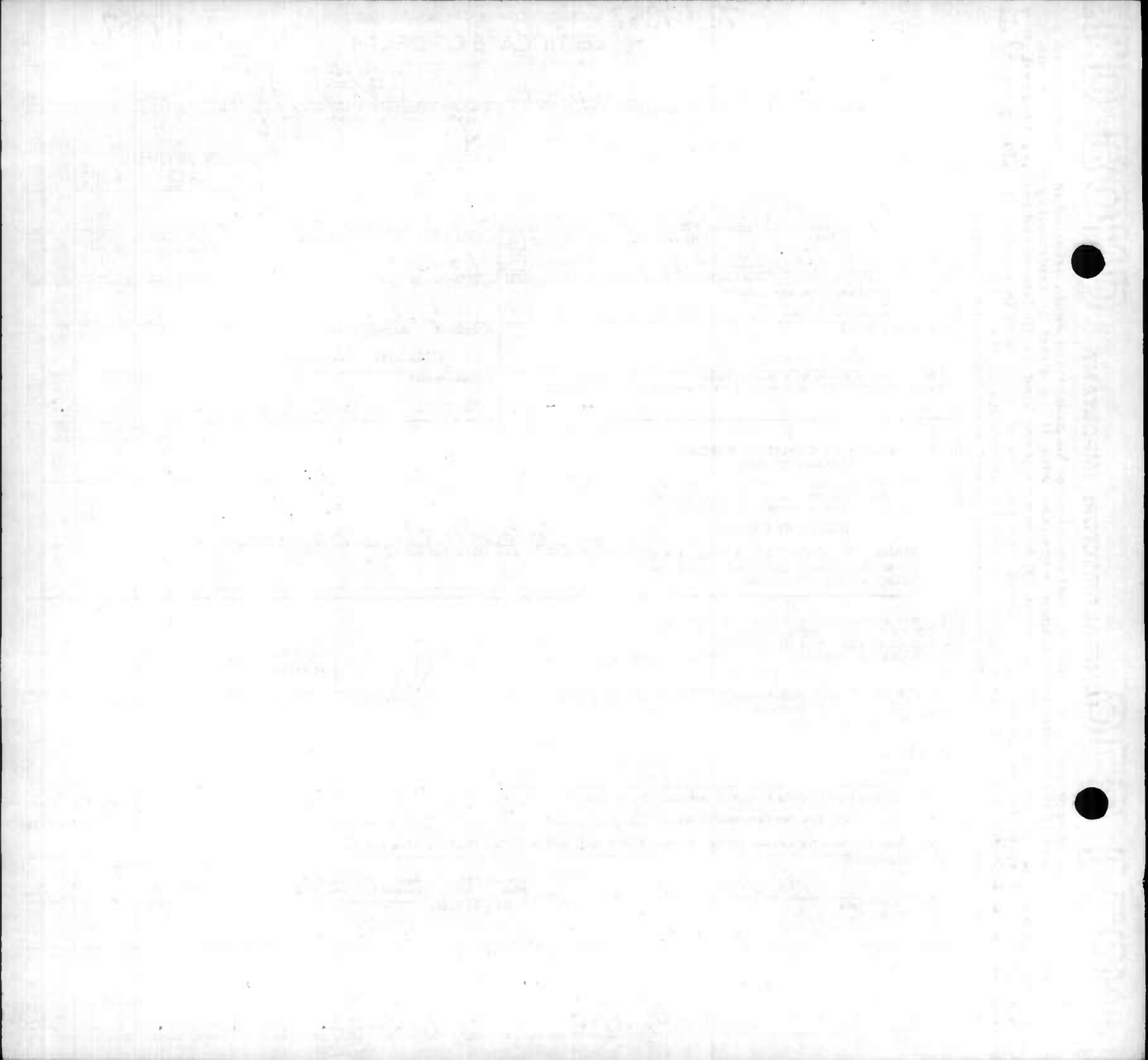
| L-000 | | 72 07386 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07386 | |
|--|--|---|--|---|--|--|--|
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| LEE, MARGARET J | | | | JULY 24, 1972 1:00 A. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE | | | |
| 00 1305 BOLTON STREET BALTIMORE, MARYLAND 21217 | | | | MARYLAND | | | |
| E. STREET AND NUMBER | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| 1305 BOLTON STREET | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| FEMALE | | WHITE | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | JAN. 19, 1903 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday) | | If Under 1 Yr. Months Days | |
| | | | | 69 | | If Under 24 Hrs. Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| | | | | | | | |
| 18. 174 X I | | CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | BREAST CARCINOMATOSIS | | | | 3 YRS. | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE | | | | | |
| ANTECEDENT CAUSES | | DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| II | | HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | | | | 5 YRS. | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 1967 to JULY 24 1972 that (I) (we) last saw the deceased alive on JULY 23 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| CARLTON L. SEXTON, M.D. | | | | JULY 24, 1972 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| | | | | 819 PARK AVE. BALTIMORE, MD. 21201 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORIUM | | 24D. STATE | |
| | | 7-31-72 | | ANATOMY BOARD OF MARYLAND | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | UNIVERSITY MEDICAL SCHOOL | | | |
| AUG 3 1972 | | [Signature] | | MORTUARY SERVICE - BCHD | | | |



FUNERAL DIRECTOR: IMPORTANT

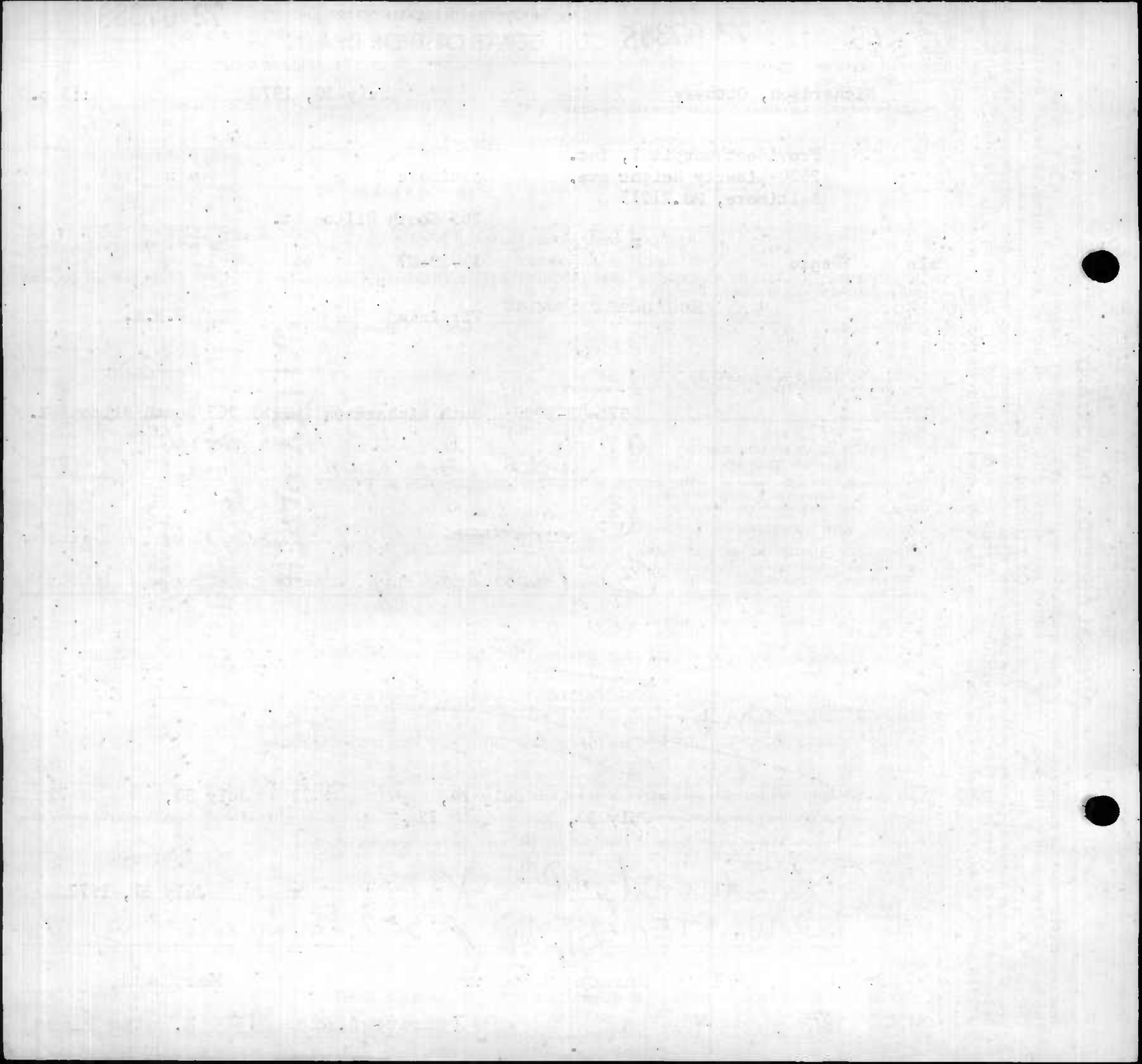
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| K-550 | | 72 07387 BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07387 | | | |
|--|-------------------------|---|-------------------------------------|---|--|---|--|
| BIRTH NO. | | CERTIFICATE OF DEATH | | | | STATE OF MARYLAND - DHMH | |
| 1. NAME OF DECEASED (Type or Print) <u>Kennedy Elisa</u> | | 2. DATE AND HOUR OF DEATH <u>3 1/2 p.m. Aug. 1, '72</u> | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2552</u> | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>43 South Baltimore General Hospital</u> | | IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | E. STREET AND NUMBER <u>404 Swale Rd.</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>Black</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-12-19</u> | 9. AGE (In years last birthday) <u>52</u> | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>School System</u> | | 11. BIRTHPLACE (State or foreign country) <u>S.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Isaiah Dozier</u> | | 14. MOTHER'S MAIDEN NAME <u>Pauline Gibson</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>229-26-6270</u> | | 17. INFORMANT ADDRESS <u>Marvin Kennedy 404 Swale Rd Balto. Md</u> | | | |
| 18. <u>56019 I</u> | | CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Respiratory failure</u> | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <u>Intestinal obstruction</u> DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (C) _____ | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Aug. 31, 9:30 p.m. 1972</u> to <u>Aug. 1, 3 1/2 a.m. 1972</u> that (I) (we) last saw the deceased alive on <u>Aug. 1, 2:50 a.m. 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>P. W. Wang</u> | | 23B. DATE SIGNED <u>Aug. 1, '72</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Phel Wao Wang</u> | | 23D. ADDRESS <u>S. B. G. H.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>8/5/72</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Park</u> | | 24D. LOCATION (City, town, or county) (State) <u>Arbutus, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 3 1972</u> | | 25B. NAME OF REGISTRAR <u>Charles A. Rice</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>1300 N. Eutaw Place</u> | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | 72 07388 | | REG. NO. 72 07388 | |
|---|-------------------------|---|--|---|---|
| BIRTH NO. R-263 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Richardson, Ottoway | | | 2. DATE AND HOUR OF DEATH July 30, 1972 4:15 p.m. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS & LOCATION) Provident Hospital, Inc. 2600 Liberty Height Ave. Baltimore, Md. 21215 | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2006 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 265 South Hilton St. | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-29-07 | 9. AGE (In years last birthday) 64 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook | | 10B. KIND OF BUSINESS OR INDUSTRY Schindler Peanut | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME | | |
| 14. MOTHER'S MAIDEN NAME | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. 578-05-8996 | | | 17. INFORMANT Ruth Richardson (WIFE) 265 South Hilton St. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart disease with Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF: 1 year | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 2. Pericarditis and pleuritis DUE TO, OR AS A CONSEQUENCE OF: 1 week | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 3. Pulmonary Infarction DUE TO, OR AS A CONSEQUENCE OF: 1 week | | | | | |
| 19A. DATE OF OPERATION no | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) yes | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | |
| 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 24, 1972 to July 30, 1972 , that (I) (we) last saw the deceased alive on July 30, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE D. W. Stewart, M.D. | | | 23B. DATE SIGNED July 31, 1972 | | |
| 23C. PHYSICIAN'S NAME (Type) D. W. STEWART, M.D. | | | 23D. ADDRESS 2300 Garrison Blvd. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/5/72 | | 24C. NAME OF CEMETERY OR CREMATORY Harmony Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Maryland | | 25A. DATE REC'D BY HEALTH DEPT. AUG 3 1972 | | | |
| 25B. NAME OF REGISTRAR Sidney Johnson | | 25C. FUNERAL DIRECTOR Charles A. Rice | | | |
| ADDRESS 1300 N. Eutaw Place | | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | 72 07389 | | X | | REG. NO. 72 07389 | |
| B-653 | | | | STATE OF MARYLAND-DHMH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Brandford, Mrs. Daisy</u> | | | | 2. DATE AND HOUR OF DEATH <u>7/25/72</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Bon Secour Hospital</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>AA</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bon Secour Hospital</u> | | | | C. CITY OR TOWN <u>BALTO.</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <u>F</u> 6. RACE <u>B</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH <u>12-1-98</u> | | 9. AGE (in years last birthday) <u>73</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Worker</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>Edward Branford</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Idella Grayson</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>214-46-1035</u> | | 17. INFORMANT <u>Idella Thompson</u> ADDRESS <u>1725 Nursery Rd.</u> | |
| 18. <u>4124 I</u> CAUSE OF DEATH | | | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Recurrent CVA</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF: | | <u>Weeks</u> | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7/24/72</u> 19 <u> </u> to <u>7/25/72</u> 19 <u> </u> that (I) (we) last saw the deceased alive on <u>7/25/72</u> 19 <u> </u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Cherlan</u> | | | | 23B. DATE SIGNED <u>7/25/72</u> | | 23C. PHYSICIAN'S NAME (Type) <u>CHAINAN</u> | |
| 23D. ADDRESS <u>BON SECOURS HOSP.</u> | | | | 23E. DEGREE <u>Attending Phys.</u> <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>8-7-72</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Mt. Winans, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 3 1972</u> | | 25B. NAME OF REGISTRAR <u>Lindsey H. Wilson</u> | | 25C. FUNERAL DIRECTOR <u>Charles A. Rice</u> | | ADDRESS <u>1300 N. Eutaw Place</u> | |

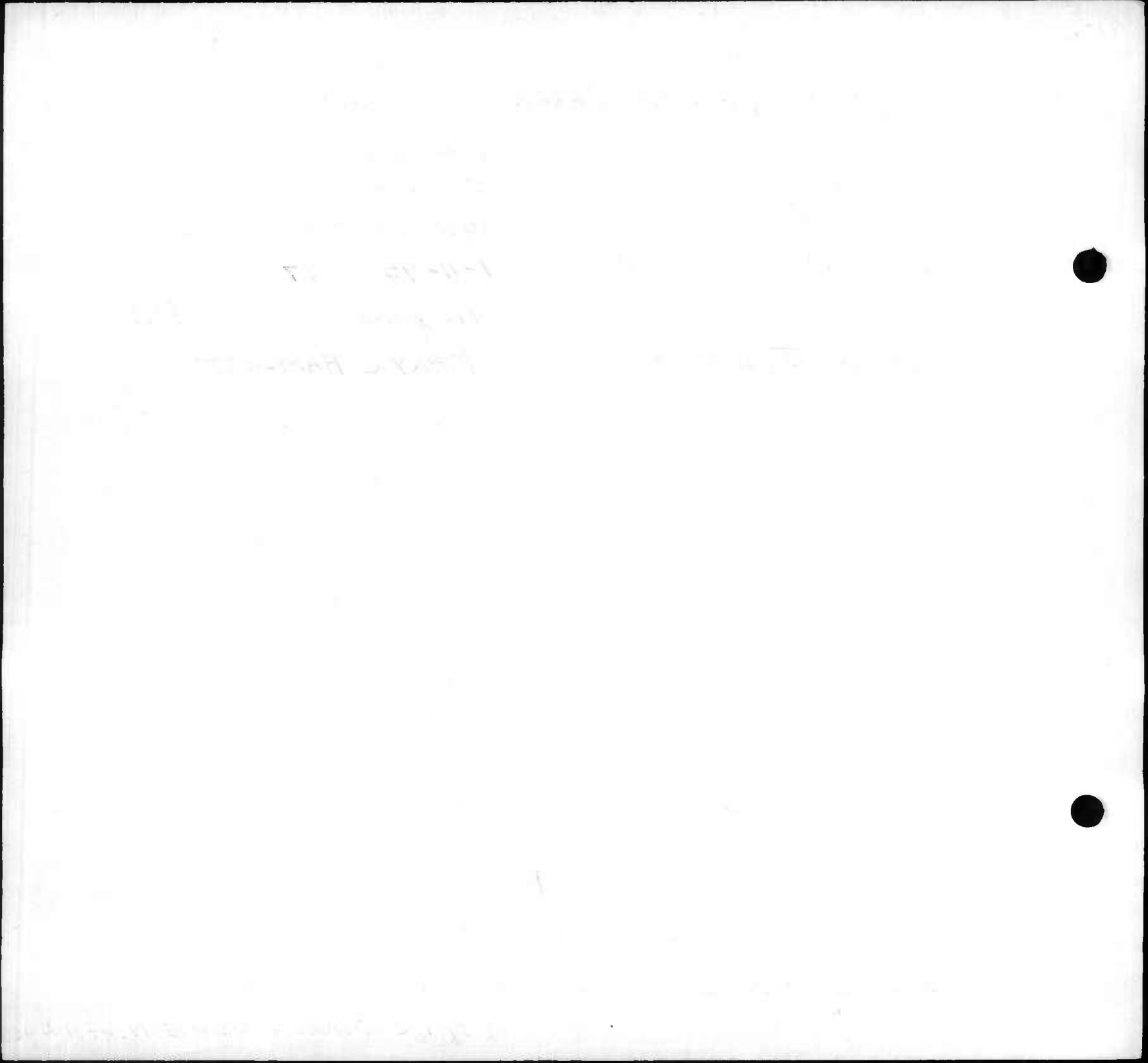
301 Bishop Ave. A A Co.

2/12/68

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 72 07390 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07390 | |
|---|--|---|--|--|--|
| BIRTH NO. | | MAY | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | STATE OF MARYLAND-DHMH | |
| MASON, ALMA BAKER | | 7/29/72 | | 7: A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | 1502 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET, ADDRESS OR LOCATION) | | A. STATE B. COUNTY | | C. CITY OR TOWN | |
| 46 LUTHERAN Hospital Baltimore, Md. 21216 | | MARYLAND | | BALTIMORE | |
| D. INSIDE CITY LIMITS? | | E. STREET AND NUMBER | | 1611 MCKEAN AVE. | |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5. SEX 7 | | 6. RACE B | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1-11-95 | | 9. AGE (In years lost birthday) 77 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME WILLIAM J. BAKER | | 14. MOTHER'S MAIDEN NAME MARY C HAMLETT | | 12. CITIZEN OF WHAT COUNTRY U.S. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT (SISTER) ALICE B. DAVENPORT (Same) | |
| 18. CAUSE OF DEATH | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | Circumline Near Failure | |
| ANTECEDENT CAUSES | | (B) Anterior to the Heart Disease DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) _____ | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7 - 26 19 72 to 7 - 29 19 72 that (I) (we) last saw the deceased alive on 7 - 29 - 72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Lourdes M. Victoria, M.D. | | 23B. DATE SIGNED 7-29-72 | | 23C. PHYSICIAN'S NAME (Type) LOURDES M. VICTORIA, M.D. | |
| 23D. ADDRESS Lutheran Hospital of Maryland | | 23E. DATE 7-31-72 | | 23F. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem. | |
| 23G. LOCATION (City, town, or county) (State) Baltimore, Md. | | 23H. DATE REC'D BY HEALTH DEPT. AUG 3 1972 | | 23I. NAME OF REGISTRAR Audrey Hinton | |
| 23J. FUNERAL DIRECTOR V.M.C. MARCH | | 23K. ADDRESS 928 E. NORTH AVE | | 23L. DATE MARCH 9 1972 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

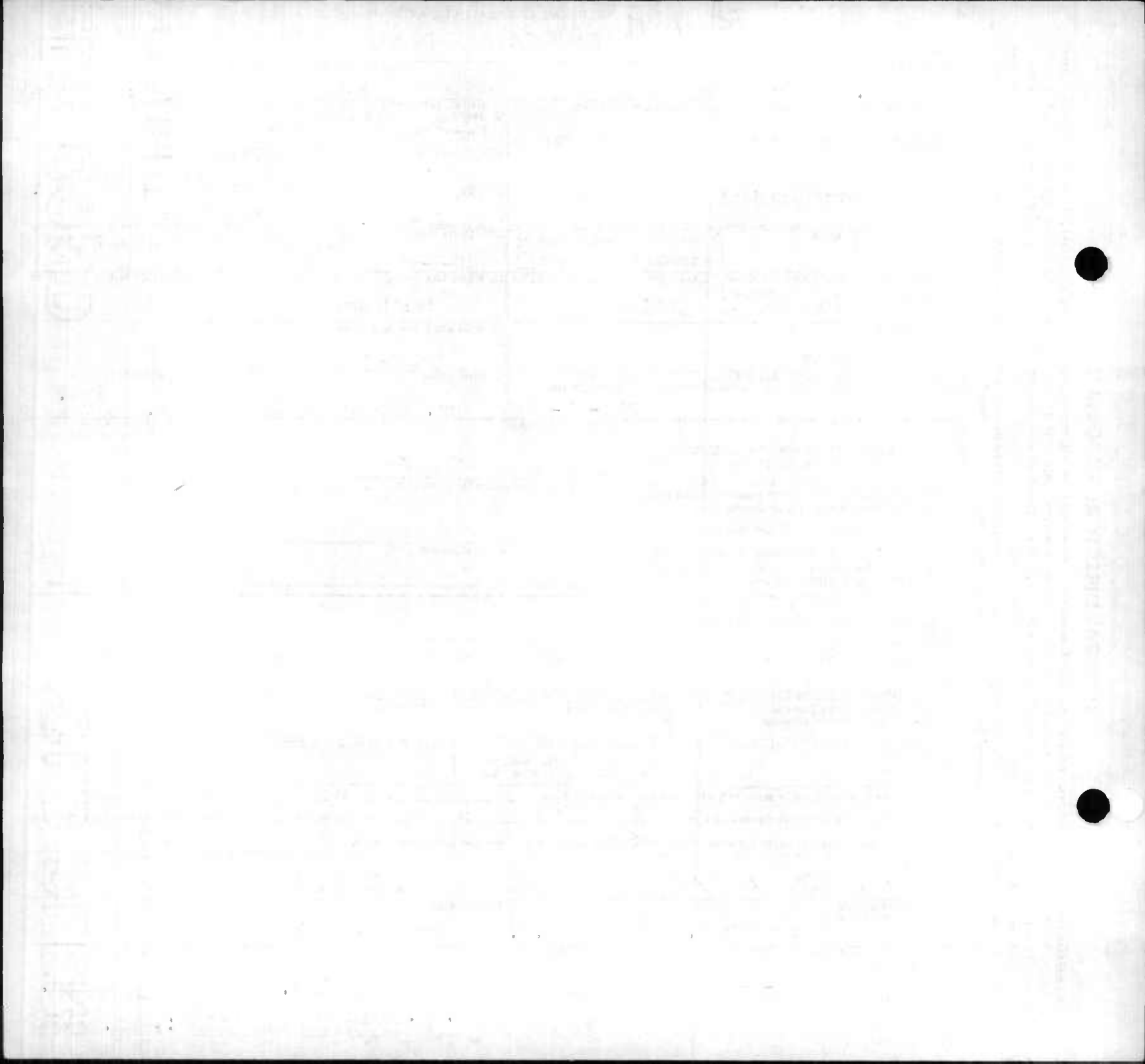
M 2601

72 07391

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 07391
STATE OF MARYLAND-DHMH

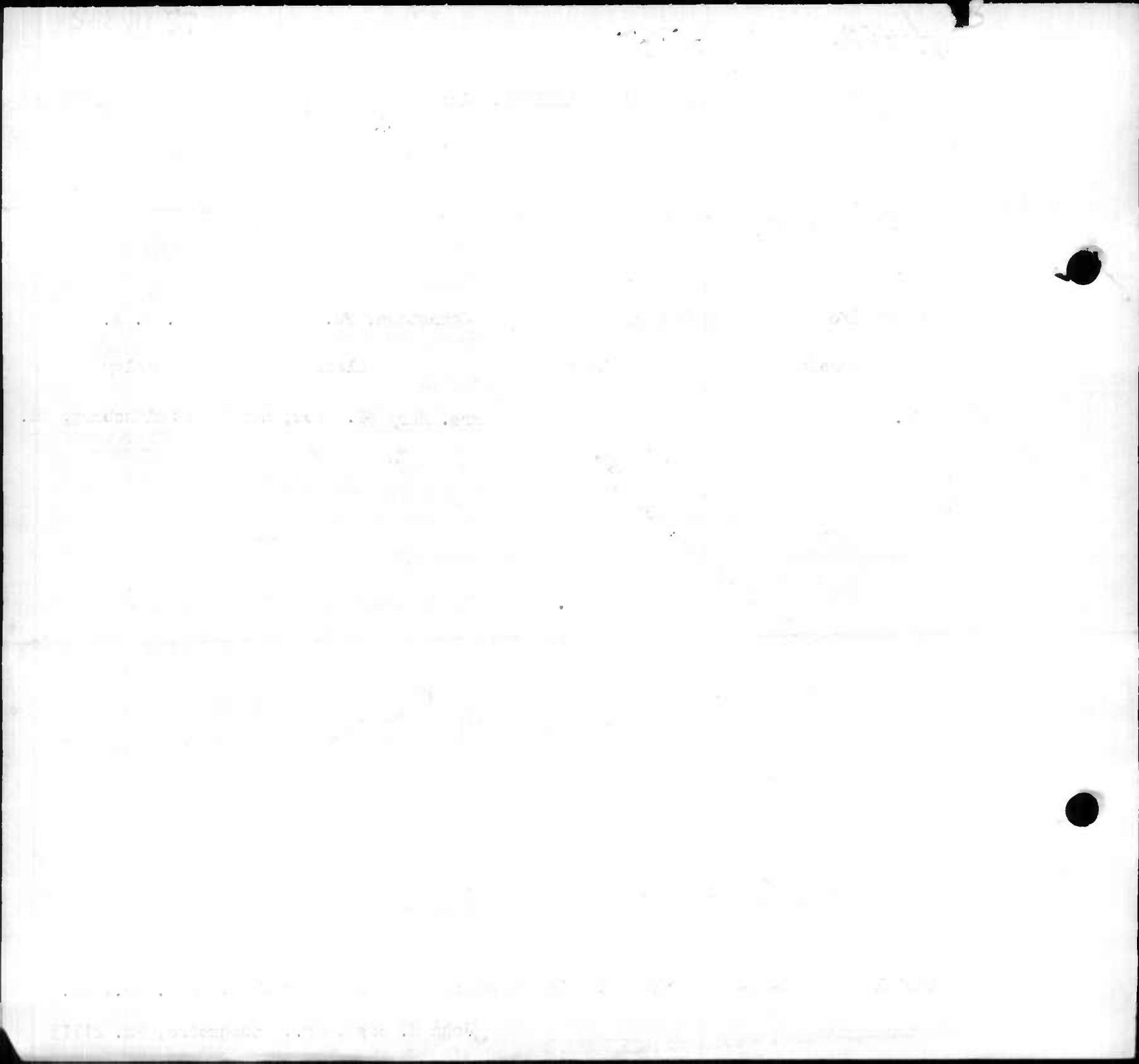
| | | | | | |
|---|---------------------|---|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) W. Roderick McRae | | 2. DATE AND HOUR OF DEATH 8-1-72 6:05 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1102 | |
| IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 24-E Mt. Vernon Place 21202 | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 10-5-99 | 9. AGE (In years last birthday) 72 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Commercial | | 10B. KIND OF BUSINESS OR INDUSTRY Artist | | 11. BIRTHPLACE (State or foreign country) Baltimore | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME George McRae | |
| 14. MOTHER'S MAIDEN NAME Mollie Mahon | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. 059-12-8184 | | | | 17. INFORMANT Mrs. Marion Voelkel 117 E. Belvedere Ave. | |
| 18. CAUSE OF DEATH 6-19-31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) COPD = hypoxemia + hyperkalemia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Renal insufficiency 2. #1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 7/27 19 72 to 8/1 19 72 that (I) (we) last saw the deceased alive on 8/1 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE Kenneth P. Warrick M.D. 23B. DATE SIGNED 8/1/72 23C. PHYSICIAN'S NAME (Type) Kenneth P. Warrick M.D. 23D. ADDRESS Mercy Hospital 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 8-4-72 24C. NAME OF CEMETERY or CREMATORY Greenmount 24D. LOCATION (City, town, or county) (State) Balto. Md. 25A. DATE REC'D BY HEALTH DEPT. AUG 3 1972 25B. NAME OF REGISTRAR Sidney H. Jenkins 25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. ADDRESS 1905 York Road Balto., Md. 21212 | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| H-452 | | 72 07392 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07392 | |
|--|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Holmes, Alfreda, Rita</u> | | | | 2. DATE AND HOUR OF DEATH <u>July 31 1972</u> <u>9:45 AM</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 University Hospital</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Washington</u> | | | |
| 5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH <u>10-21-19</u> | | 9. AGE (In years last birthday) <u>52</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Johnstown, Pa.</u> | |
| 13. FATHER'S NAME <u>Augusta</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Clara</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mrs. Mary E. Webb, Box 260B Smithsburg, Md.</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death) <u>E 812.01</u> | | | | CAUSE OF DEATH <u>Injuries</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS giving rise to the above cause, or stating the UNDERLYING CONDITION | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Multiple Trauma</u> | | <u>17 days</u> | |
| | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Blunt Force Trauma</u> | | <u>17 days</u> | |
| | | | | (C) | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Chronic Restrictive Lung Disease 16 yrs</u> | | | | | | | |
| 19A. DATE OF OPERATION <u>7/14/72</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ruptured spleen</u> | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Street</u> | | 21C. WHERE DID INJURY OCCUR? <u>Boonsboro, Maryland</u> | | 21D. HOW DID INJURY OCCUR? <u>driven in auto - auto collision</u> | |
| 21E. TIME OF INJURY (Month (Day) (Year) (Hour)) <u>7-14-72 3PM</u> | | 21F. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>July 19 1972</u> to <u>July 31 1972</u> and that (2) (we) last saw the deceased alive on <u>July 31 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Walter B. Lynd</u> | | | | 23B. DATE SIGNED <u>July 31, 1972</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Dr. J. H. East, Jr.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>8-3-72</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Pleasant View Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Burkittsville, Fred. Co., Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 3 1972</u> | | 25B. NAME OF REGISTRAR <u>Dr. J. H. East, Jr.</u> | | 25C. FUNERAL DIRECTOR <u>John H. East, Jr.</u> | | ADDRESS <u>Boonsboro, Md. 21713</u> | |



B-635

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) M. CHESTER BURDINSKI | | | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 7 29 1972 4 p M. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 1440 E. Fort Ave. (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 29 1972 4 p M. | | | |
| 6. SEX male | | | | 7. RACE white | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH July 20, 1918 | | | | 10. AGE (In years last birthday) 54 | | 11. BIRTHPLACE (State or foreign country) West Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME Walter Burdinski | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) checker | |
| 15. MOTHER'S MAIDEN NAME Stefania Kicke | | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes World War II | | | |
| 17. SOCIAL SECURITY NO. 205-03-8980 | | | | 18. INFORMANT ADDRESS Anna Burdinski 1401 Andre St | | | |
| 19. CAUSE OF DEATH Hypertensive cardiovascular disease | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| 20A. DATE OF OPERATION 8/2/72 | | | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 21. AUTOPSY? (Yes or No) no | | | | | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | | | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 22F. HOW DID INJURY OCCUR? | | | | | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Marvin S. Platt EXAMINER'S NAME (Type) | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DATE SIGNED 7-31-72 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 8/2/72 | | | |
| 24C. NAME OF CEMETERY or CREMATORY Gettysburg National Cemetery | | | | 24D. LOCATION (City, town, or county) (State) Gettysburg, Pennsylvania | | | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 3 1972 | | | | 25B. NAME OF REGISTRAR Andrew Whitson | | | |
| 25C. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc. | | | | ADDRESS 31502 East Fort Avenue | | | |

July 20, 1918

Wm. H. H. H.

July 20, 1918

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Wm. H. H. H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>72 07394</u> | |
|--|-------------------------|---|--|--|--|
| BIRTH NO. <u>B-340</u> | | | | STATE OF MARYLAND-DEMD | |
| 72 07394 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>JOSEPH BYTELLA</u> | | | 2. DATE AND HOUR OF DEATH <u>7/30/72</u> <u>9</u> <u>20</u> PM M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>43 SOUTH BALTIMORE GENERAL HOSPITAL</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1408 ANDRE ST.</u> | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1/2/12</u> | 9. AGE (In years last birthday) <u>60 YRS</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LONG SHOREMAN</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>PIER 3 CHESEBROUGH OPERATING CO.</u> | | 11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u> | | | 13. FATHER'S NAME <u>PETER Bytella</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>? Mary Kejan</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | |
| 16. SOCIAL SECURITY NO. <u>213-10-3998</u> | | | 17. INFORMANT <u>Mary Bytella</u> | | |
| 18. ADDRESS <u>1408 Andre St.</u> | | | 19. CAUSE OF DEATH <u>HEPATIC COMA.</u> | | |
| 20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ANTECEDENT CAUSES</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>PANCREATITIS.</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>?</u> | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (initially medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (this hospital) attended the deceased from <u>6/26</u> 19 <u>72</u> to <u>7/30</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>7/30</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | 23A. SIGNATURE <u>Bokeffe MD.</u> | | |
| 23B. DATE SIGNED <u>7/30/72</u> | | | 23C. PHYSICIAN'S NAME (Type) <u>Bokeffe MD.</u> | | |
| 23D. ADDRESS <u>1408 Andre St.</u> | | | 23E. DEGREE <u>MD.</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 24B. DATE <u>8/3/72</u> | | |
| 24C. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cemetery</u> | | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 3 1972</u> | | | 25B. NAME OF REGISTRAR <u>William H. Heston</u> | | |
| 25C. FUNERAL DIRECTOR <u>Charles L. Stevens</u> | | | 25D. ADDRESS <u>1501 East Fort Avenue</u> | | |

Handwritten text at the top of the page, mostly illegible.

time

Handwritten text in the middle section, including the word "By" and "No".

NEARBY

CHURCH

INCIDENT

NO

YES

Handwritten text at the bottom, including "also" and "1/20".

Handwritten text at the bottom right, possibly "back" and "and".

Handwritten text at the very bottom of the page, mostly illegible.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07395 | | 72 07395 | |
|--|--|--|--|---|--|--|--|
| T-150 | | | | CERTIFICATE OF DEATH | | STATE OF MARYLAND-DHMH | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| Sarah THORNE | | | | July 29, 1972 | | 12 th 7 th M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE | | B. COUNTY | |
| Midtown Home, Inc. 808 St. Paul Street Baltimore, Maryland 21202 | | | | Maryland | | 2552 | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| F | | B | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 7-17-14 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | | | DARLINGTON, SOUTH CAROLINA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| NORMAN JOHNSON | | | | HATTIE BROWN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| | | | | 237-18-2350 | | PAUL THORNE 3010 SEAMON AVENUE 21225 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE | | | |
| ANTECEDENT CAUSES | | | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | Cardio Respiratory Failure | | | |
| | | | | massive Cerebral Vascular Accident | | | |
| | | | | (B) old Brain Stem CVA | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (C) Hypertension | | | |
| | | | | Diabetes Mellitus | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 12 1972 to July 29 1972 that (I) (we) last saw the deceased alive on July 29 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Willard Appleford MD | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Willard Appleford MD | | | | 6615 Kenton Rd | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | | 8-3-72 | | MOUNT CALVARY CEMETERY | | BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| AUG 3 1972 | | Sidney W. Horton | | MORTON & DYETT F. H. | | 1701 LAURENS STREET | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| L-500 1 | | 72 07396 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | REG. NO. 72 07396 | |
|--|---------|--|------------------|--|--|--|------------------------------|---|--|
| BIRTH NO. | | STATE OF MARYLAND - DHMH | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| | | | | Maggie Lane | | 8/2/72 | | 1 830 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE | | B. COUNTY | |
| THE JOHNS HOPKINS HOSPITAL | | | | | | Md | | 807 | |
| | | | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | | | | | Baltimore City | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | | | E. STREET AND NUMBER | | | |
| | | | | | | 1902 East Oliver Street | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | | |
| F | Black | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8/4/14 | 58 | B+O Employee | Emporia Virginia | U.S.A. | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| James Lane | | | | Addie Lane | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| | | | | | | Raymond Lane - 703-Mt Healey St | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | 6-Days | |
| ANTECEDENT CAUSES | | | | Respiratory-Cardiac | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | Probably Pulmonary Process of Unknown Etol. | | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | Yes | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 19 19 72 to Aug 2 19 72 that (I) (we) last saw the deceased alive on Aug 2 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | | | |
| J. R. DE PAULO M.D. | | | | 8/2/72 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| | | | | THE JOHNS HOPKINS HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) | | (State) | |
| Burial | | 8-8-72 | | Antioch Bapt Cem. | | Emporia, Virginia | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| AUG 4 1972 | | Dorothy H. Hinton | | Gloria D. H. Hinton | | 1701 - Laurens St. | | | |

82

14

Abbie Lane
Hingham, Mass.

Dear Abbie

I have just received your letter of the 14th and am glad to hear from you. I am well and hope this finds you the same.

Yours truly,
John

John
Hingham, Mass.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 3172 07397 | |
|---|--|--|--|---|--|
| BIRTH NO. 72 07397 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) MAGGIE HAWKINS | | 2. DATE AND HOUR OF DEATH 7/28/72 2 40 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HARBOR VIEW NURSING CENTER 1213 LIGHT ST. BALTIMORE, MD. | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY 1702 | | | |
| 5. SEX F | | 6. RACE B | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTH PLACE (State or foreign country) N. Hampton Co. Virginia | |
| 13. FATHER'S NAME Peter Savage | | 14. MOTHER'S MAIDEN NAME Lettie Cozart | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 218-10-77815 | | 17. INFORMANT Bessie Snowden ADDRESS 4201 1/2 Reisterstown Dr. | |
| 18. 4124 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cardiac Arrest Sudden | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: A.S.C. U. Aneurysm | | (B) DUE TO, OR AS A CONSEQUENCE OF: ? | |
| 19. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). C. VA - Left Hemiplegia | | (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hr | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/25 19 69 to 7/28 19 72 and that (I) (we) last saw the deceased alive on 7/25 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Joseph S. Blum | | 23B. DATE SIGNED 8/1/72 | | 23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-5-72 | | 24C. NAME of CEMETERY or CREMATORY St. Calvary Cem. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 4 1972 | | 25B. NAME OF REGISTRAR John J. ... | | 25C. FUNERAL DIRECTOR Edward Dett ... | |

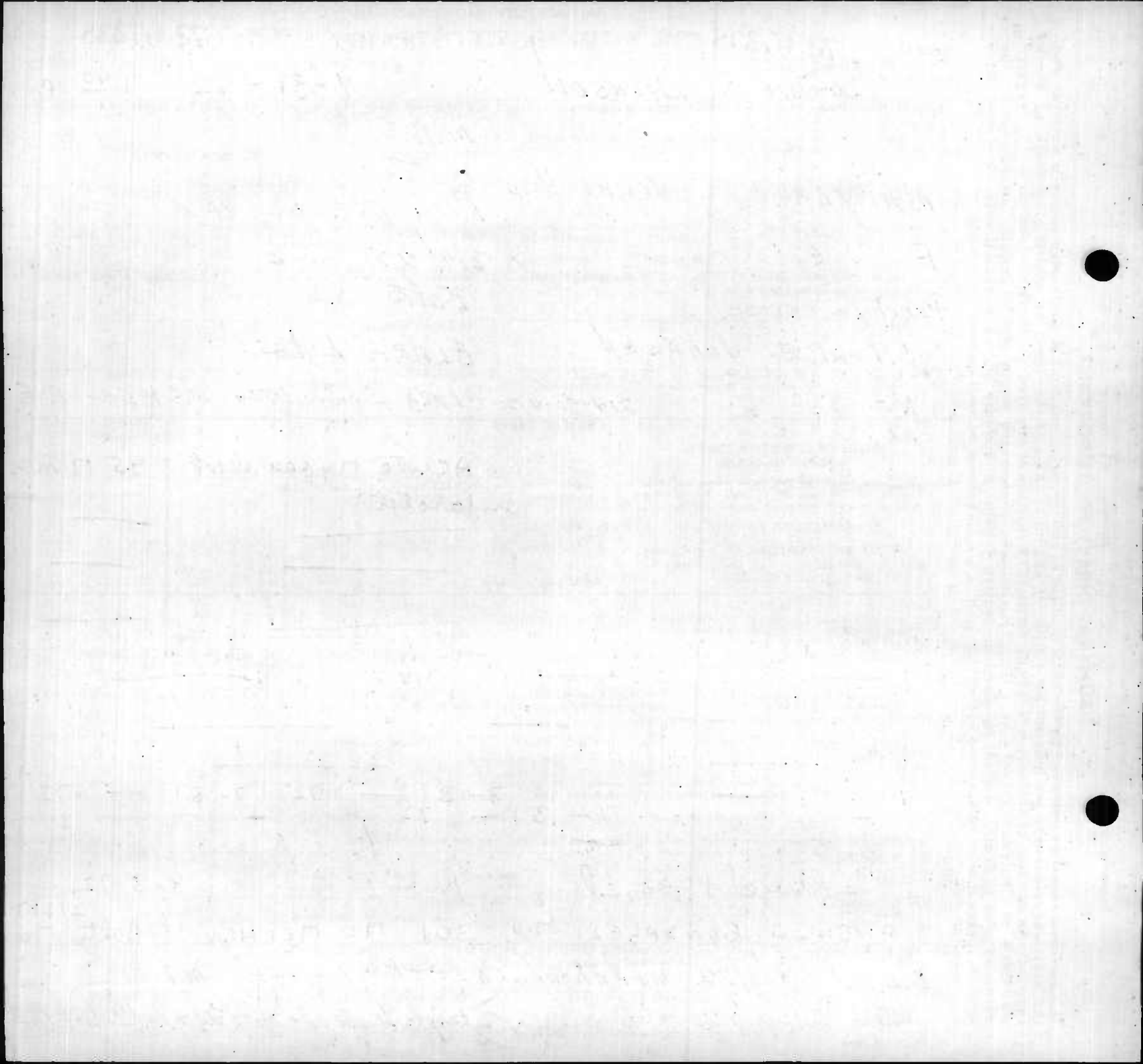
1/28/69 - Adm.

422 Cummins, Cl.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

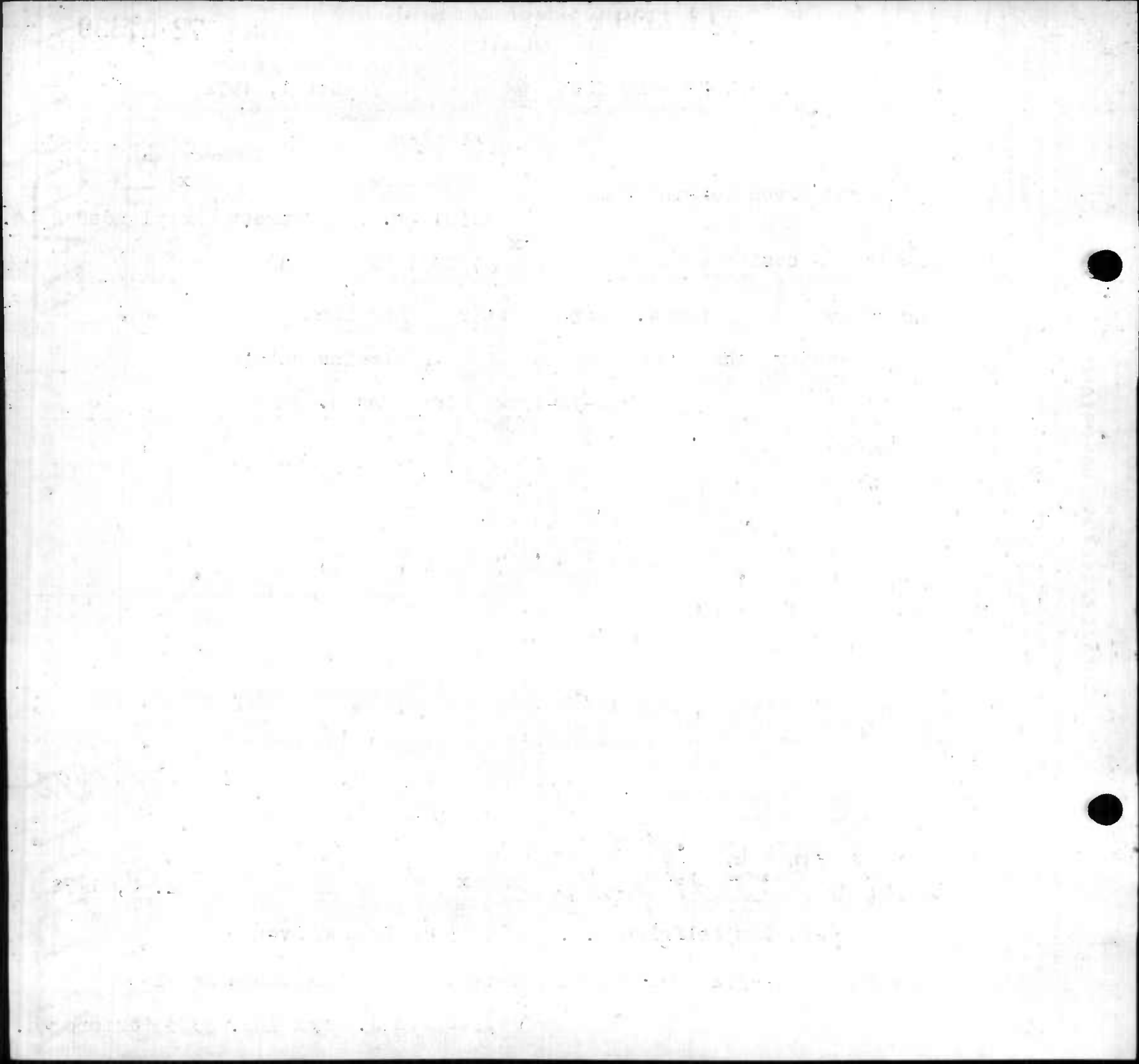
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|--|-----------------------------------|--|--|--|---|---|------------------------------------|--|--|
| BIRTH NO. 72 07398 | | | | | STATE OF MARYLAND | | | | | |
| 1. NAME OF DECEASED (Type or Print) Dorothy E. Johnson | | | | | 2. DATE AND HOUR OF DEATH 7-31-72 1:40 P.M. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL Hosp | | | | | A. STATE Md | | B. COUNTY 1502 | | | |
| | | | | | C. CITY OR TOWN Balto | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | | E. STREET AND NUMBER 1714 McKean Ave | | | | | |
| 5. SEX F | | 6. RACE E. N | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH 8/4/25 | | 9. AGE (In years lost birthday) 46 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRACTICAL NURSE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Balto, Md | | 12. CITIZEN OF WHAT COUNTRY? | | | | |
| 13. FATHER'S NAME CHARLIE JOHNSON | | | | | 14. MOTHER'S MAIDEN NAME CLARA LYLES | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | | 16. SOCIAL SECURITY NO. 214-20-4790 | | 17. INFORMANT CLARA Scott 1714 MCKEAN AVE | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | | CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute myocardial infarction | | | | 45 MINUTES | |
| | | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| | | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (the hospital) attended the deceased from 7-31-1972 to 7-31-1972, that (I) (we) last saw the deceased alive on 7-31-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE Dr. Angels Gonzalez | | | | | DEGREE | | 23B. DATE SIGNED 8-3-72 | | | |
| 23C. PHYSICIAN'S NAME (Type) ANGELS. GONZALEZ M.D. | | | | | 23D. ADDRESS 301 Mc Nechen St Balto-Md 21217 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/5/72 | | 24C. NAME OF CEMETERY or CREMATORY Md NATIONAL MEM. PK | | 24D. LOCATION (City, town, or county) (State) LAUREL Md | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. 8/14/1972 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR Joseph B. Locke | | ADDRESS 1304 N. Central Ave | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07399 | |
|--|----------------------|---|---|--|---|
| 72 07399 CERTIFICATE OF DEATH | | | | | |
| STATE OF MARYLAND-DHMH | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | MABEL FRANCES KEHS | | August 1, 1972 4 ⁰⁰ A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 70 Long Green Nursing Home | | | A. STATE Maryland | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 3501 St. Paul Street Marylander Apts. | | |
| 5. SEX Female | 6. RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/20/1892 | 9. AGE (In years last birthday) 80 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary | | 10B. KIND OF BUSINESS OR INDUSTRY Penna. Power & Water | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Leander Kehs | | 14. MOTHER'S MAIDEN NAME Louisa Helwig | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 212-12-1962 | | 17. INFORMANT Miss Edna S. Kehs | |
| 18. 440.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Atherosclerosis</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1956 to Aug 1st 72, that (I) (we) last saw the deceased alive on July 30 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Wm J. Helfrich</i> | | | | 23B. DATE SIGNED Aug. 2, 1972 | |
| 23C. PHYSICIAN'S NAME (Type) William Helfrich M.D. | | | | 23D. ADDRESS 5006 Roland Avenue | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/4/72 | | 24C. NAME OF CEMETERY or CREMATORY Immanuel Cemetery | |
| 24D. LOCATION Baltimore Maryland | | 24E. DATE REC'D BY HEALTH DEPT. AUG 4 1972 | | 24F. NAME OF REGISTRAR <i>Adelmya...</i> | |
| 24G. FUNERAL DIRECTOR Leonard J. Ruck Inc. | | 24H. ADDRESS 5305 Harford Rd. | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07400

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Nadreau, ESTHER ~~NADREAU~~ Mary

2. DATE OF DEATH

Known ☐ Estimated ☐

Month Day Year Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (If not in hospital or institution, give street address or location)
OR INSTITUTION

1613 Woodbourne Ave.

3. DATE PRONOUNCED DEAD

Month Day Year Hour

M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Md.

B. COUNTY

2749

6. SEX

female

7. RACE

white

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

11/22/04

10. AGE (In years last birthday)

67

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1613 Woodbourne Ave.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Gustav C. Radke

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Homemaker Ret. Acme Mkts. Bakery

15. MOTHER'S MAIDEN NAME

Johanna Boudenbach

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

220-20-8021

18. INFORMANT

ADDRESS

Mr. Frederick M. Wood Sr. 1611 Winford R.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Hypertensive & arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-30-72

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/3/72

24C. NAME OF CEMETERY OR CREMATORY

Meadowridge Cemetery

24D. LOCATION (City, town, or county) (State)

Dorsey Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 4 1972

25B. NAME OF REGISTRAR

Audrey H. Boston

25C. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck Inc. 5305 Harford Rd.

RECEIVED

197

11/11/71

220-30-021

Robert

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07401

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
 STATE OF MARYLAND-DEME

REG. NO.

72 07401

BIRTH NO.

1. NAME OF DECEASED
 (Type or Print)

COLEMAN MOLLY LAVELLE

2. DATE AND HOUR OF DEATH

AUGUST 1 19 72 10:45A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
 HOSPITAL OR
 INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
 ADDRESS OR LOCATION)

ST AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
 A. STATE B. COUNTY

MD.

C. CITY OR TOWN

BALTO.

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

3906 COLCHESTER RD BALTO MD 21229

5. SEX

FEMALE

6. RACE

CAUCASIAN

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

04 23 17

9. AGE (In years
 last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
 Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
 done during most of working life, even if retired)

HSWF

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

MILTON L GRIFFIN

14. MOTHER'S MAIDEN NAME

IRENE ATKINS

15. Was Deceased Ever in U. S. Armed Forces?
 (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
 SECURITY NO.

217-01-8106

17. INFORMANT ADDRESS

WILKENS & CATON AVE.
 ST AGNES HOSPITAL RECORDS -

18. 410.9 I

DISEASE OR CONDITION DIRECTLY
 LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
 heart failure, asthenia, etc. It means the disease,
 injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
 rise to the above cause (A) stating the
 UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
 BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
 TO THE DEATH BUT NOT RELATED TO THE TERMINAL
 DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
 WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
 IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
 OR CONTRIBUTING CAUSE OF
 DEATH (nately medical examiner)

21B. PLACE OF INJURY (e.g., in or about
 home, farm, factory, street, office bldg.,
 etc.)

21C. WHERE DID
 INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
 OF INJURY
 (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
 Work ☐

Not While
 At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from JULY 15 19 72 to AUGUST 1 19 72,
 that (X) (we) last saw the deceased alive on AUGUST 1 19 72 and that in my (our) opinion death occurred on the date
 and hour and from the causes stated above. (I) (We) (did) (XXXX) view the body after death.

23A. SIGNATURE

E. Benjamin

Attending
 Phys. ☐

Med.
 Director ☐

Staff
 Phys. ☒

23B. DATE SIGNED

8/1/72

23C. PHYSICIAN'S
 NAME (Type)

EITATSU HENZAN

23D. ADDRESS

24A. BURIAL CREMATION,
 REMOVAL (Specify)

Burial

24B. DATE

8/4/72

24C. NAME OF CEMETERY or CREMATORY

Loudon Park

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 4 1972

25B. NAME OF REGISTRAR

Frederick MacNabb

25C. FUNERAL DIRECTOR

Edw. S. MacNabb Sons, Inc.
 301 Frederick Rd. Catonsville, Md.

COLLEGE: HOLLY LAVERIE

AUGUST 1 1973

ST AGNES HOSPITAL

FEMALE CAUSATION

ON 23 17

MSW

MARYLAND

HILTON J. GRIFFIN

IRENE ATKINS

WILKINS & CATEN AVE

217-01-6100 ST AGNES HOSPITAL RECORDS

NO

AUGUST 1

JULY 12

XX

XXXX

AUGUST 1

Battal 8/4/73

London Park

Baltimore, Maryland

301 Frederick Rd. Catonsville, Md.
S. S. Macdonald Sons, Inc.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|---|--|
| 72 07402 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07402 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | STATE OF MARYLAND - DEPT. | |
| 1. NAME OF DECEASED (Type or Print) <u>COOK, LOLLIE</u> | | 2. DATE AND HOUR OF DEATH <u>7/27/72</u> <u>6:30 P.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 UNIVERSITY HOSPITAL</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>MO.</u> B. COUNTY <u>1703</u> | | C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <u>FEMALE</u> | | 6. RACE <u>N</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH <u>1/1/95</u> | | 9. AGE (In years last birthday) <u>77</u> | | 10. Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>LABOR</u> | | 11. BIRTHPLACE (State or foreign country) <u>MO</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>ARTHUR COMMODORE</u> | | 14. MOTHER'S MAIDEN NAME <u>FLORENCE</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>219-32-1608</u> | | 17. INFORMANT <u>PATIENT</u> ADDRESS | |
| 18. <u>1971.91</u> CAUSE OF DEATH | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (A) IMMEDIATE CAUSE <u>Pneumonia (R lung)</u> | | DUE TO, OR AS A CONSEQUENCE OF: | | <u>3 days</u> | |
| (B) <u>atrial tachycardia</u> | | DUE TO, OR AS A CONSEQUENCE OF: | | <u>7/12 - 7/21/72</u> | |
| (C) <u>Gastric carcinoma</u> | | DUE TO, OR AS A CONSEQUENCE OF: | | <u>4 months</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>5/31/72</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Gastric CA</u> | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? Involuntarily medical examiner <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5/10</u> 19 <u>72</u> to <u>7/27</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>7/27</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Philip J. Schriever, M.D.</u> | | 23B. DATE SIGNED <u>7/27/72</u> | | 23C. PHYSICIAN'S NAME (Type) <u>PHILIP J. SCHRIEVER, M.D.</u> | |
| 23D. ADDRESS <u>UNIV. HOSPITAL</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>8/1/72</u> | | 24C. NAME of CEMETERY or CREMATORY <u>ARROW CEM.</u> | |
| 24D. LOCATION (City, town, or county) <u>Back Hall Kent</u> | | (State) <u>MD</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 4 1972</u> | | 25B. NAME OF REGISTRAR <u>Andrew W. H. H. H.</u> | | 25C. FUNERAL DIRECTOR <u>Wm. H. H. H.</u> ADDRESS <u>Chestertown, Md.</u> | |

1

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND-DEMH

REG. NO.

72 07403

BIRTH NO.

| | | | | |
|--|-------------------------|---|--|--|
| 1. NAME OF DECEASED (Type or Print) MICHAEL CHILDS | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 1, 1972 | | M. |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If not in hospital or institution, give street address or location) 38 UNIVERSITY HOSPITAL | | 3. DATE PRONOUNCED DEAD Month Day Year August 1, 1972 | | Hour 5:20 P. |
| 6. SEX Male | 7. RACE White | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Union Town |
| 9. DATE OF BIRTH June 20, 1954 | | 10. AGE (In years lost birthday) 18 | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 11. BIRTHPLACE (State or foreign country) Penna. | | 12. CITIZEN OF U.S.A. | | E. STREET AND NUMBER Box 41 |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant | | 14B. KIND OF BUSINESS OR INDUSTRY Gas Service Station | | 13. FATHER'S NAME Roland R. Childs |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. | | 15. MOTHER'S MAIDEN NAME Barbara Brown |
| 18. INFORMANT Mrs. Barbara Childs, Uniontown, Maryland | | ADDRESS | | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Blunt force injury to chest | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | |
| 20A. DATE OF OPERATION 2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) yes |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Balto. Co. and Anne Arundel County Greenspring Valley Rd. and Craddocks Rd. |
| 22D. TIME OF INJURY (APPROX.) 8-1-72 1:31 P. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Driver in motorcycle/auto accident |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Aug. 4, 1972 | 24C. NAME of CEMETERY or CREMATORY St. Joseph's Cemetery | 24D. LOCATION (City, town, or county) (State) Taneytown, Carroll Co., Md. |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 4 1972 | | 25B. NAME OF REGISTRAR <i>Sydney [illegible]</i> | | 25C. FUNERAL DIRECTOR ADDRESS Skiles Funeral Home, Taneytown, Maryland |

June 20, 1954

Harold A. Miller

U.S.A.

Point

Barbara Brown

San Antonio Station

Atlanta

Mr. Barbara Miller, Wilmington, Delaware

From: [illegible]

Subject: [illegible]

Reference: [illegible]

Enclosure: [illegible]

Very truly yours,

[illegible signature]

[illegible title]

[illegible address]

[illegible city]

[illegible state]

[illegible zip]

[illegible phone]

[illegible telex]

[illegible cable]

[illegible fax]

[illegible email]

[illegible internet]

[illegible social media]

[illegible other]

[illegible signature]

[illegible title]

[illegible address]

[illegible city]

[illegible state]

[illegible zip]

[illegible phone]

[illegible telex]

[illegible cable]

[illegible fax]

[illegible email]

[illegible internet]

[illegible social media]

[illegible other]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>72 07404</u> | |
|---|-----------|--|--|--|------------------------------|
| 72 07404 CERTIFICATE OF DEATH STATE OF MARYLAND-DHMH | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | WENCK, RICHARD PHILIP | | AUGUST 1, 1972 5:50A .M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>40</u> ST. AGNES HOSPITAL | | | A. STATE MARYLAND CITY 21230 | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | E. STREET AND NUMBER 1714 MONTEREY ST. <u>2553</u> | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| MALE | CAUCASIAN | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 07 13 11 | 61 | U.S.A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| SERVICE STATION | | GASOLINE | | MARYLAND | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| MILLARD WENCK | | | JOSEPHINE (Nothnagel) | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| NO | | 213030071 | | RECORDS OF ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTO., MD. 21229 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | (A) IMMEDIATE CAUSE | | |
| ANTECEDENT CAUSES | | | DUE TO, OR AS A CONSEQUENCE OF: | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | Respiratory failure | | |
| | | | Bronchogenic carcinoma | | |
| | | | Metastasis to liver & bone | | |
| | | | DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | (C) _____ | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JULY 30 19 72 to AUGUST 1 19 72, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on AUGUST 1 19 72 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| <u>Kuang-yen Huang M.D.</u> | | | | 8 1 72 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| HUANG-YEN HUANG | | | | ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTO., MD. 21229 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 8-4-1972 | | Meadowridge Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| AUG 4 1972 | | <u>Sidney Johnston</u> | | <u>Glenn H. Hubbard</u> | |
| 24D. LOCATION (City, town, or county) (State) | | | | | |
| Wash, Blvd. Howard Co., Md. | | | | | |
| 4107 Wilkens Ave. 21229 | | | | | |

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

100

18

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07405 | | REG. NO. 72 07405 | |
|--|-------------------------|---|-------------------------------------|--|------------------------------|---|--|
| BIRTH NO. 72 07405 | | | | CERTIFICATE OF DEATH | | STATE OF MARYLAND - DEPT. HEALTH | |
| 1. NAME OF DECEASED (Type or Print) DIMAIO, AUGUSTINE | | | | 2. DATE AND HOUR OF DEATH AUGUST 1, 1972 3:40 P. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) WILKENS & CATON AVENUE BALTIMORE, MARYLAND 21229 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN CATONSVILLE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 308 RADSTOCK ROAD 21228 | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-09-85 | 9. AGE (In years last birthday) 86 | 10. Under 1 Yr. Months: Days | 11. Under 24 Hrs. Hours: Min. | 12. CITIZEN OF WHAT COUNTRY? ITALY |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED-MANAGER | | | | 10B. KIND OF BUSINESS OR INDUSTRY FRIUT STORE | | 11. BIRTHPLACE (State or foreign country) ITALY | |
| 13. FATHER'S NAME AUGUSTINE DIMAIO | | | | 14. MOTHER'S MAIDEN NAME TERESA XXXX VINCENTI ROSE VINCENTI DEC 'D | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 212074400 | | 17. INFORMANT BALTO. MD. 21229 ST. AGNES HOSPITAL, WILKENS & CATON AVE. | |
| 18. 4124 I + 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Coma - stroke - ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ① Diabetes Mellitus - ② ALL pneumonia - ③ kidney involvement | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: stroke - (B) DUE TO, OR AS A CONSEQUENCE OF: A.S.C.V.D. - C.H.F. (C) ① Diabetes Mellitus - ② ALL pneumonia - ③ kidney involvement | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from JULY 25 19 72 to AUGUST 1 19 72 , that (I) (we) last saw the deceased alive on AUGUST 1 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Alejandro Mejia MD</i> DEGREE | | | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) ALEJANDRO MEJIA MD DEGREE | |
| 23D. ADDRESS St Agnes Medical Center | | | | 23E. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-4-1972 | | 24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery | | 24D. LOCATION (City, town, or county) (State) Wash. Blvd. Howard Co., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 4 1972 | | 25B. NAME OF REGISTRAR <i>Sydney B. Houston</i> | | 25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | |

1913, AUGUSTINE

AUGUST 1, 1913

MARYLAND

CATONSVILLE

308 RADSTOCK ROAD

10-12-12

ITALY

INTERCA (VICENTII)

BALTO, MD, 1913

21207400

NO

ST. AGNES HOSPITAL, WILKINS & CATON AVE.

JULY 25

AUGUST 1

AUGUST 1

1913

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|---|--|--|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | 72 07406 | | REG. NO. 72 07406 | |
| BIRTH NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) MARY FRANCES RUCKLE | | | 2. DATE AND HOUR OF DEATH 8-1-72 9 15 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore | | |
| FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS Hospital | | | C. CITY OR TOWN ARBUS D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| E. STREET AND NUMBER 1119 GLOBIA AVE. 21227 | | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/06/79 | 9. AGE (in years last birthday) 92 8X3 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | | 10B. KIND OF BUSINESS OR INDUSTRY | | |
| 11. BIRTHPLACE (State or foreign country) Washington D.C. | | | 12. CITIZEN OF WHAT COUNTRY? USA. | | |
| 13. FATHER'S NAME MICHAEL MURKANEY | | | 14. MOTHER'S MAIDEN NAME XXXXXXXXXXXXXXXXXXXX Harriet Morrow | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 215-500480 | | |
| 17. INFORMANT Mr. F. Edgar Ruckle, 212 Burke Ave. 21204 | | | ADDRESS | | |
| 18. 710.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) acute anterior - septal infarct - ~ 3 day. | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 8/1/72 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/1/72 19 to 8/1/72 19 that (I) (we) last saw the deceased alive on 8/1/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Chaihan | | | 23B. DATE SIGNED 8/1/72 | | |
| 23C. PHYSICIAN'S NAME (Type) CHAIHAN | | | 23D. ADDRESS | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-4-1972 | | 24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 4 1972 | | 25B. NAME OF REGISTRAR Sydney B. Hubbard | | 25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229 | |

THE SECRETARY OF THE ARMY
WASHINGTON, D. C.
JANUARY 1, 1917

GENERAL ORDER

NO. 1

TO THE COMMANDING GENERAL

OF THE ARMY

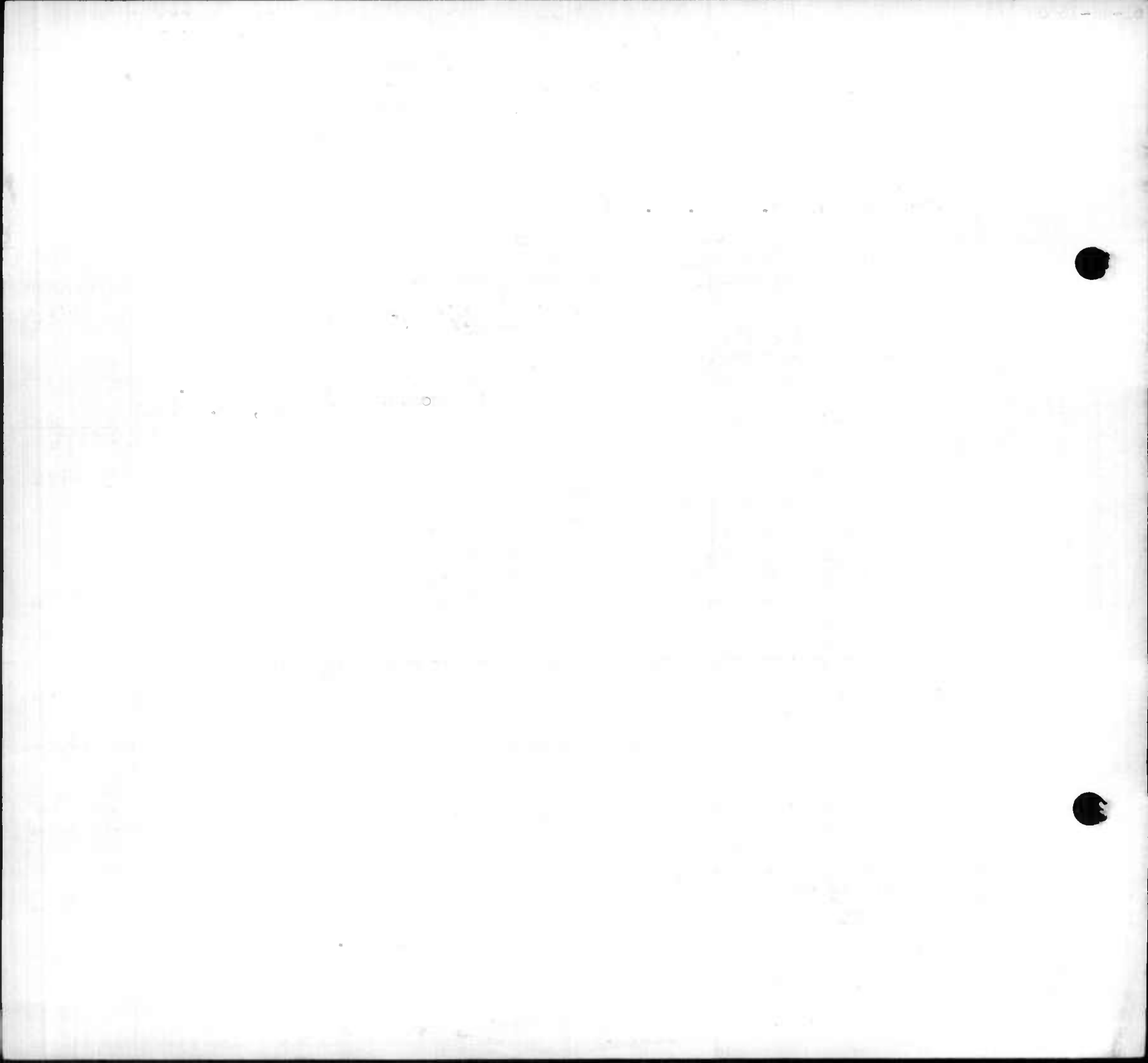
CHIEF

OF THE ARMY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | 72 07407 | |
|---|--|---|--|
| BIRTH NO. <i>W-452</i> | | REG. NO. <i>72 07407</i> | |
| 1. NAME OF DECEASED (Type or Print) <i>WILLIAMS, BABY GIRL CHERYL</i> | | 2. DATE AND HOUR OF DEATH <i>7-16-72 3:15 A.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>BALTIMORE CITY HOSPITALS. 4940 Eastern Ave. Balto. Md. 21224</i> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>DORCHESTER</i> | |
| 5. SEX <i>Female</i> 6. RACE <i>NEGRO</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>7-13-72</i> 9. AGE (in years last birthday) <i>—</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i> | |
| 10B. KIND OF BUSINESS OR INDUSTRY <i>—</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>MARYLAND, USA</i> | |
| 13. FATHER'S NAME <i>HERBERT DASHIEL WILLIAMS</i> | | 14. MOTHER'S MAIDEN NAME <i>VIOLET GALE</i> | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>BCH Records:</i> ADDRESS <i>4940 Eastern Ave. Baltimore, Md. 21224</i> | | | |
| 18. <i>776-21</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 DAYS</i> | |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>CARDIO RESPIRATORY FAILURE DUE TO PREMATURITY</i> | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: <i>AND RESPIRATORY DISTRESS SYNDROME</i> | | | |
| (C) | | | |
| 19A. DATE OF OPERATION <i>7-26-72</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) <i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (H) (this hospital) attended the deceased from <i>7-13-1972</i> to <i>7-16-1972</i> that (H) (we) last saw the deceased alive on <i>7-16-1972</i> and that (H) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>H. P. Kulasinghe</i> M.D. DEGREE | | 23B. DATE SIGNED <i>7-16-72</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>DR. H. P. KULASINGHE</i> | | 23D. ADDRESS <i>BALTIMORE CITY HOSPITALS, BALTO, MD. 4940 Eastern Ave. 21224</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i> | | 24B. DATE <i>7-26-72</i> | |
| 24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore City Hospitals</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland 21224</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>AUG 4 1972</i> | | 25B. NAME OF REGISTRAR <i>Andrew Johnson</i> | |
| 25C. FUNERAL DIRECTOR <i>3403</i> | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>72 07408</u> | |
|---|-------------------------|---|-------------------------------------|---|--|
| BIRTH NO. <u>72 07408</u> | | CERTIFICATE OF DEATH <small>STATE OF MARYLAND-DEM</small> | | | |
| 1. NAME OF DECEASED (Type or Print) <u>LUIS REISSIG</u> | | 2. DATE AND HOUR OF DEATH <u>8-2-72</u> | | 2:40 <i>P.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2775</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33</u> | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <u>100 CROSS KEYS RD APT 1</u> | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-08-97</u> | 9. AGE (In years last birthday) <u>74</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PROFESSOR</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Education</u> | | 11. BIRTHPLACE (State or foreign country) <u>ARGENTINA</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>ARGENTINA</u> | | 13. FATHER'S NAME <u>LUIS REISSIG</u> | | 14. MOTHER'S MAIDEN NAME <u>ANNA TORIJA</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>DR. MAGDELINA REISSIG</u> | |
| 18. <u>44091</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cardio respiratory arrest</u> | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>myocardial failure</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>atherosclerosis</u> (C) <u>parkinsonism</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>gas embolism</u> | | | | | |
| 19A. DATE OF OPERATION <u>Aug 1 1972</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>gas embolism</u> | | 20A. AUTOPSY (Yes or No) <u>None</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) 1 (Month) 1 (Day) 1 (Year) 1 (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>July 1972</u> to <u>Aug 2 1972</u> that (I) (we) last saw the deceased alive on <u>Aug 2 1972</u> and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>David O. Bone M.D.</u> | | 23B. DATE SIGNED <u>Aug 2, 1972</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>DAVID O. BONE</u> | | 23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u> | | 24B. DATE <u>8-3-1972</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Louisa Park Crematory</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore MD</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 4 1972</u> | | | |
| 25B. NAME OF REGISTRAR <u>John W. Cook</u> | | 25C. FUNERAL DIRECTOR <u>John W. Cook Brooks Towson, Inc. Towson, Md</u> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--------------|---|---|--|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | 72 07409 | | 72 07409 | |
| CERTIFICATE OF DEATH STATE OF MARYLAND-DMH | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Mrs. Francis Walker | | 10 10 7-31-72 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Bow Secours | | | A. STATE 3623 M. Ford Ave 2841 | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | B. COUNTY | | |
| | | | C. CITY OR TOWN Baltimore | | |
| | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | E. STREET AND NUMBER Maryland | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-12-21 | 9. AGE (In years last birthday) 51 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Co. | | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Wallace Groome | | | 14. MOTHER'S MAIDEN NAME Bessie White | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. 215-14-5973 | | 17. INFORMANT John F. Walker - Same |
| 18. 571.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Lung Cancer DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that (in) (my) (our) apintan death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Felimon A. Soria M.D. | | | | 23B. DATE SIGNED 7-31-72 | |
| 23C. PHYSICIAN'S NAME (Type) FELIMON A. SORIA M.D. | | | | 23D. ADDRESS Bow Secours Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 8-4-72 | | 24C. NAME of CEMETERY or CREMATORY Lower United Methodist Church Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Hartfield, VA. | | 25A. DATE REC'D BY HEALTH DEPT. AUG 4 1972 | | | |
| 25B. NAME OF REGISTRAR Sydney W. ... | | 25C. FUNERAL DIRECTOR Hemagost Funeral Chapel 4600 Liberty Light Ave | | | |

1-21-50

Myland

USA

Telephone Co -

The Kunkin - Lane

Butler 24-25 Jones County, Georgia

James Earl Ray, 441 N. 1st St., St. Paul, Minn.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07410

BIRTH NO.

STATE OF MARYLAND-DEME

1. NAME OF DECEASED
(Type or Print)

EARL E. HEINLEIN Sr.

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

woods, 3101 Swann Drive

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

7

28

1972

3:20 p

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

YES ☒NO ☐

6. SEX

male

7. RACE

white

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

9. DATE OF BIRTH

Jan. 26, 1927

10. AGE (In years
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

10 W. Preston St.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

George H. Heinlein

14A. USUAL OCCUPATION (Give kind at work
done during most of working life, even if retired)

Labor

14B. KIND OF BUSINESS OR INDUSTRY

A. & P. Bakery

15. MOTHER'S MAIDEN NAME

Spphia B.

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

219-10-8162

18. INFORMANT

ADDRESS

Earl E. Heinlein, Jr.

19.

E955X

CAUSE OF DEATH

Shotgun wound of head

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A.

DATE OF OPERATION

1

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A.

EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

?

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

?

22D.

TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

?

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

Suicide - shot self

~~Unintentional - found in woods~~

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ ~~Unintentional manner~~

ACTUAL

SIGNATURE

EXAMINER'S

NAME (Type)

Marvin S. Platt, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-29-72

24A. BURIAL CREMATION,
REMOVAL (Specify)

Cremation

24B. DATE

8/2/72

24C. NAME of CEMETERY or CREMATORY

Security Process, Inc. Baltimore, Md.

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 4 1972

25B. NAME OF REGISTRAR

Audrey W. Horton

25C. FUNERAL DIRECTOR

John J. Duda 7922 Wise Ave. Dundalk, Md.

ADDRESS

8-29-1972 - Letter from the Office of the Chief Medical Examiner, Marvin S. Platt, M.D.
Assistant Medical Examiner

HRS

Jan. 26, 1972
USA
Maryland
George H. Reinecke
Sophie B.
212-10-8162 Earl E. Reinecke, Jr.
Baltimore
Maryland
10 W. Preston St.

Continuation 8/17/72
Security Process, Inc. Baltimore, MD.
John A. Duda

58-13-31 djr

72 07411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 07411

BIRTH NO.

1. NAME OF DECEASED Thomas J. Bowers
(Type or Print)

Bowers Thomas

2. DATE AND HOUR OF DEATH

July 31, 1972 7:20 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES ☐ NO ☒

E. STREET AND NUMBER 1945 Haselmere Road 21222

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

8-22-07

9. AGE (In years last birthday)

64

10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Driver

10B. KIND OF BUSINESS OR INDUSTRY

Balto.-N.Y. Express

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William H. Bowers

14. MOTHER'S MAIDEN NAME

Carrie O.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL SECURITY NO.

215-03-4763

17. INFORMANT

BCH: RECORDS 4940 Eastern Avenue
Baltimore, Maryland 21224

ADDRESS

18. 162.1 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cerebral herniation

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Metastatic Ca

(C)

Ca of lung

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6-16 1972 to July 31 1972 that (I) (we) last saw the deceased alive on 7-31 1972 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

J. Anderson MD

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

7/31/72

23C. PHYSICIAN'S NAME (Type)

J. Anderson, M.D.

DEGREE

23D. ADDRESS

Baltimore City Hospitals
4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-2-72

24C. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cemetery

24D. LOCATION (City, town, or county) (State)

Glen Burnie, Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 4 1972

25B. NAME OF REGISTRAR

Sidney [Signature]

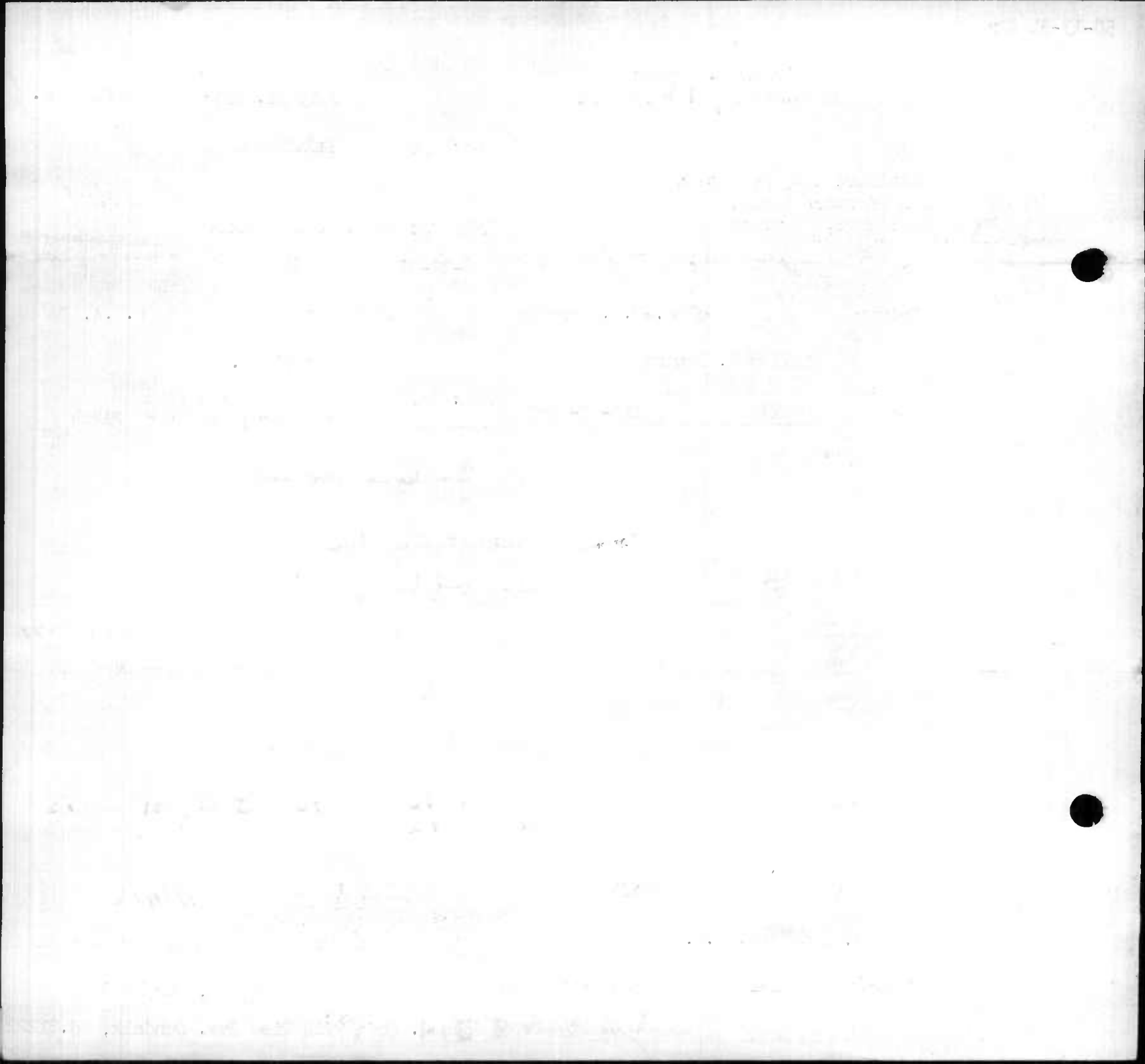
25C. FUNERAL DIRECTOR

John J. Duda 7922 Wise Ave. Dundalk, Md. 21222

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



59-75-37 pm 1

72 07412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 07412

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)Harry J. Hawthorne
Harry Hawthorne

2. DATE AND HOUR OF DEATH

7/30/72

6:40 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
HOSPITAL OR ADDRESS OR LOCATION)
INSTITUTION

Baltimore City Hospitals

31 4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY

Maryland Baltimore

C. CITY OR TOWN

Dundalk

D. INSIDE CITY LIMITS?

YES ☐No ☒

E. STREET AND NUMBER

4004 St. Mohica Drive 21222

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

3/24/30

9. AGE (in years
last birthday)

42

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Foreman

10B. KIND OF BUSINESS OR INDUSTRY

Beth. Steel Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James E. Hawthorne, Sr.

14. MOTHER'S MAIDEN NAME

Anna A. Carpenter

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

1947-1950

16. SOCIAL
SECURITY NO.

212-24-5960

17. INFORMANT

ADDRESS

BCH Records 4940 Eastern Ave. 21224

18.

284X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Thrombocytopenia

(B) DUE TO, OR AS A CONSEQUENCE OF:

Aplastic Anemia

(C) DUE TO, OR AS A CONSEQUENCE OF:

Acute Myelogenous Leukemia

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Susp. Intracranial Hemorrhage? minutes

6 mos.

6 mos.

7 mos

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

No

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from July 5 1972 to July 30 1972
that (I) (we) last saw the deceased alive on July 30 1972 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (We) (did) (did not) view the body after death.

23A. SIGNATURE

Paul F. Ryan MD

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

7/30/72

23C. PHYSICIAN'S
NAME (Type)

Paul F. Ryan M.D.

DEGREE

23D. ADDRESS

4940 Eastern Ave.

Baltimore City Hospitals Balto. Md. 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8-2-72

24C. NAME OF CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 4 1972

25B. NAME OF REGISTRAR

Sidney H. Keston

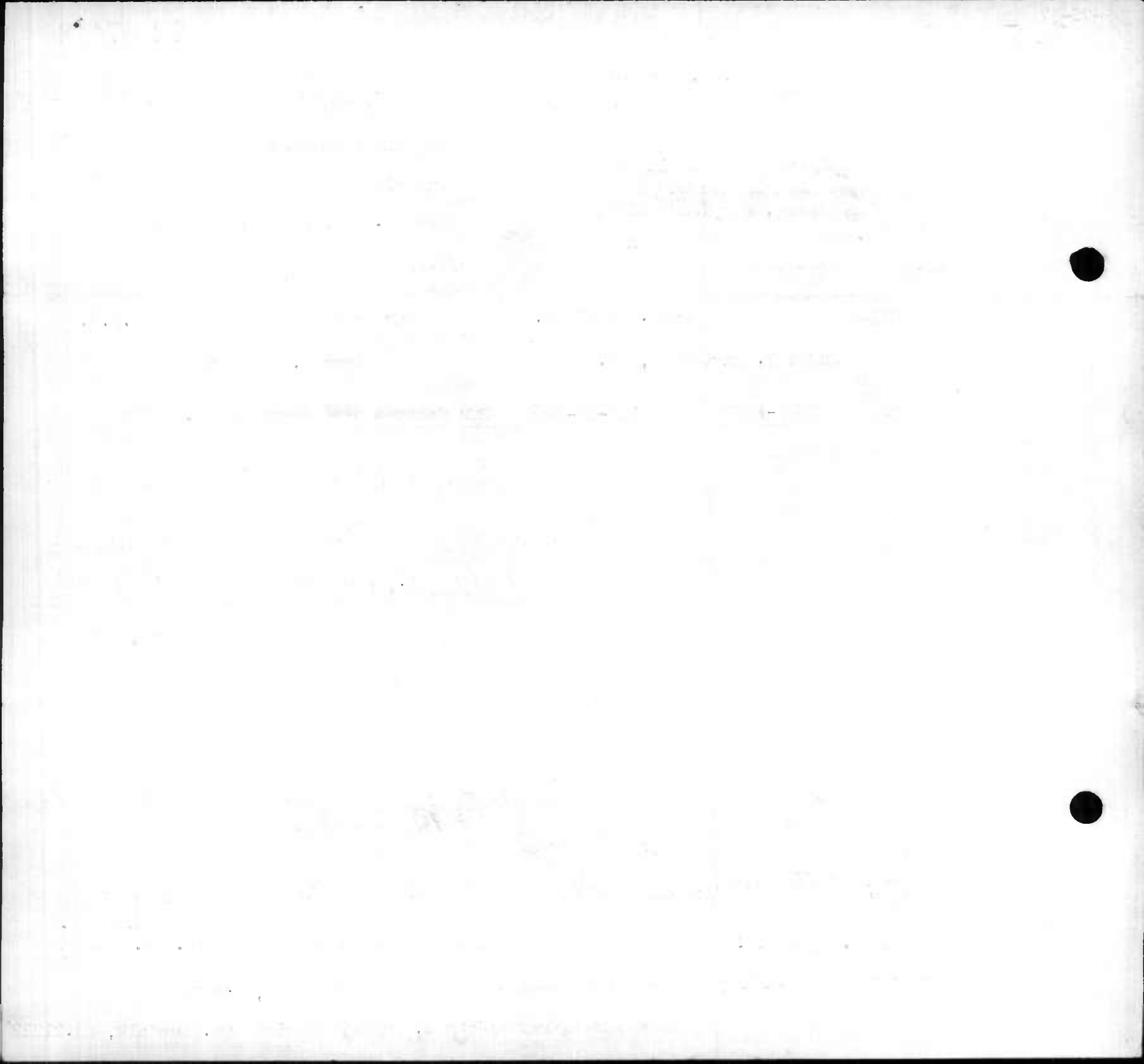
25C. FUNERAL DIRECTOR

John J. Duda 7922 Wise Ave. Dundalk, Md. 21222

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | | | |
|---|--|---------------------------|--|--|--|--|--|---|--|
| BIRTH NO. | | 72 07413 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | | 72 07418 | |
| 1. NAME OF DECEASED (Type or Print) | | Mr. Joseph G. Snyder, Jr. | | STATE OF MARYLAND - DEPT. | | DATE AND HOUR OF DEATH | | August 2, 1972 7-21 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | A. STATE | | B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital | | | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | Md. 21230 | | 2403 | |
| 5. SEX M | | | | 6. RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6-19-96 | |
| 9. AGE (In years last birthday) 75 yrs | | | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Sup. | |
| 13. FATHER'S NAME Andrew Snyder | | | | 14. MOTHER'S MAIDEN NAME Clara V. Weaver | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 212 10 8693 | |
| 17. INFORMANT Joseph G. Snyder, Jr. | | | | ADDRESS 206 East Fort Avenue Balto., Md. 21230 | | 18. 58 2X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Chronic Renal failure DUE TO, OR AS A CONSEQUENCE OF: (B) Chr. Granular nephritis and Chr. pyelo-nephritis (C) Arteriosclerotic Cardiovascular Disease | | | |
| 19A. DATE OF OPERATION 2 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 7/21/1972 to 8/2/1972 that (I) (we) lost saw the deceased alive on 8/2/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Bharat Acari | | | | 23B. DATE SIGNED 8/2/72 | | 23C. PHYSICIAN'S NAME (Type) Bharat Acari | | | |
| 23D. ADDRESS Maryland General Hospital | | | | 23E. FUNERAL DIRECTOR Gully Funeral Home | | 23F. ADDRESS 130 East Fort Ave. Balto., Md. 21230 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 8-7-72 | | 24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 4 1972 | | | | 25B. NAME OF REGISTRAR [Signature] | | 25C. FUNERAL DIRECTOR Gully Funeral Home | | | |

[Faint, illegible text, likely bleed-through from the reverse side of the page]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | |
|---|--|--|--|--|--|
| 72 07414 | | 72 07414 | | 72 07414 | |
| <div> <div>1. NAME OF DECEASED (Type or Print)</div> <div>2. DATE AND HOUR OF DEATH</div> </div> | | | | | |
| <div>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</div> | | <div>4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)</div> | | | |
| <div> <div>FULL NAME OF HOSPITAL OR INSTITUTION</div> <div>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</div> </div> | | <div> <div>A. STATE</div> <div>B. COUNTY</div> </div> | | | |
| <div>7 MERCY HOSPITAL</div> | | <div> <div>MARYLAND</div> <div>C. CITY OR TOWN</div> <div>BALTIMORE</div> <div>D. INSIDE CITY LIMITS?</div> <div>YES <input type="checkbox"/> NO <input type="checkbox"/></div> </div> | | | |
| <div>5. SEX</div> <div>MALE</div> | | <div>6. RACE</div> <div>WHITE</div> | | <div>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></div> | |
| <div>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>PROPRIETOR</div> | | <div>10B. KIND OF BUSINESS OR INDUSTRY</div> <div>REAL ESTATE</div> | | <div>8. DATE OF BIRTH</div> <div>86</div> | |
| <div>11. BIRTHPLACE (State or foreign country)</div> <div>Austria</div> | | <div>12. CITIZEN OF WHAT COUNTRY?</div> <div>USA</div> | | | |
| <div>13. FATHER'S NAME</div> <div>CHASKEL MAILMAN</div> | | <div>14. MOTHER'S MAIDEN NAME</div> <div>SARAH HECHT</div> | | | |
| <div>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</div> <div>NO</div> | | <div>16. SOCIAL SECURITY NO.</div> <div>215-30-2099</div> | | <div>17. INFORMANT</div> <div>MR. LLOYD S. MAILMAN, 10 LIGHT ST., #21202</div> | |
| <div>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div> <div>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</div> <div>ANTECEDENT CAUSES</div> <div>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</div> | | <div>CAUSE OF DEATH</div> <div>(A) IMMEDIATE CAUSE</div> <div>DUE TO, OR AS A CONSEQUENCE OF:</div> <div>Auto Myocardial Infarction</div> <div>(B) Anteriosclerotic heart disease</div> <div>DUE TO, OR AS A CONSEQUENCE OF:</div> <div>years.</div> | | <div>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</div> <div>1 h.</div> | |
| <div>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</div> | | | | | |
| <div>19A. DATE OF OPERATION</div> <div>0</div> | | <div>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</div> | | <div>20A. AUTOPSY (Yes or No)</div> <div>No</div> | |
| <div>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</div> | | <div>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</div> | | <div>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</div> | |
| <div>21D. TIME OF INJURY (APPROX.)</div> <div>(Month) (Day) (Year) (Hour)</div> | | <div>21E. INJURY OCCURRED</div> <div>White At <input type="checkbox"/> Not White At Work <input type="checkbox"/></div> | | <div>21F. HOW DID INJURY OCCUR?</div> | |
| <div>22. I certify that (I) (this hospital) attended the deceased from 7/16 1972 to 7/20 1972</div> <div>that (I) (we) last saw the deceased alive on 7/30 1972 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</div> | | | | | |
| <div>23A. SIGNATURE</div> <div>Toku Ohe MD</div> | | <div>23B. DATE SIGNED</div> <div>7/30/72</div> | | <div>23C. PHYSICIAN'S NAME (Type)</div> <div>Toku Ohe MD</div> | |
| <div>24A. BURIAL CREMATION, REMOVAL (Specify)</div> <div>BURIAL</div> | | <div>24B. DATE</div> <div>8/2/72</div> | | <div>24C. NAME OF CEMETERY OR CREMATORY</div> <div>BETH TFILOH</div> | |
| <div>24D. LOCATION</div> <div>BALTIMORE, MARYLAND</div> | | <div>24E. ADDRESS</div> <div>Mercy Hospital, Baltimore MD</div> | | | |
| <div>25A. DATE REC'D BY HEALTH DEPT.</div> <div>AUG 4 1972</div> | | <div>25B. NAME OF REGISTRAR</div> <div>Dr. J. H. H. H.</div> | | <div>25C. FUNERAL DIRECTOR</div> <div>6010 REISTERSTOWN ROAD</div> | |

RECEIVED

ALL

NO

1924

WHEAT ESTATE

PROPERTY

SARAH ESTATE

CLAUDE E. HAYMON

111-20-2000 MR. JAMES S. WILSON, JR. 111-20-2000

RECEIVED

RECEIVED

RECEIVED

RECEIVED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|--|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | 72 07415 | |
| M-320 | | 72 07415 | |
| BIRTH NO. | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| LENA, MATZ | | 7/31/72 1:35PM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | |
| Sinai Hosp. of Baltimore | | Md. | |
| 42 | | 2717 | |
| 5. SEX | | 6. RACE | |
| FEMALE | | WHITE | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | - | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 9. AGE (In years last birthday) | |
| Housewife | | 80 years | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| AT HOME | | RUSSIA | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| BELINGKA | | - | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| NO | | - | |
| 17. INFORMANT | | ADDRESS | |
| MRS. MAY M. RUBIN, 11 SLADE AVE., APT. 912 #8 | | - | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE | |
| ANTECEDENT CAUSES | | DUE TO, OR AS A CONSEQUENCE OF: | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| - | | - | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | - | |
| - | | - | |
| II | | A.S.C.U.D | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | - | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| - | | - | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| - | | - | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | |
| - | | - | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX) | |
| - | | - | |
| 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | - | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/22/1972 to 7/31/1972 that (I) (we) last saw the deceased alive on 7/31/1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | |
| R. SUDHINDRA | | 7/31/72 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | |
| R. SUDHINDRA | | Sinai Hosp. of Baltimore | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | |
| BURIAL | | 8/1/72 | |
| 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BETH EL MEMORIAL PARK | | RANNEY RANDALLSTOWN, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | |
| AUG 4 1972 | | Sol Levinson & Bros. | |
| 25C. FUNERAL DIRECTOR | | ADDRESS | |
| - | | 6010 REISTERSTOWN ROAD | |

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

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72 07416

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND

REG. NO. 72 07416

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ISAAC BECKERMAN

2. DATE
OF
DEATHKnown ☐ Estimated ☐ Month Day Year Hour M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF (If not in hospital or institution, give street address or location)

CERTIFICATE AMENDED

Sinai Hospital (DOA)

3. DATE
PRONOUNCED DEADMonth Day Year Hour M.
7 31 1972 10:31aM.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

2740

6. SEX

male

7. RACE

white

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

10/25/13
10/27/101210. AGE (In years
last birthday)

50 58 57

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3314 Glen Ave.

11. BIRTHPLACE (State or foreign country)

POLAND

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

DAVID BECKERMAN

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

ELECTRICIAN

14B. KIND OF BUSINESS OR INDUSTRY

MD. CUP CO.

15. MOTHER'S MAIDEN NAME

SARAH ?

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL
SECURITY NO.

219-30-5732

18. INFORMANT

ADDRESS

MRS. GINA BECKERMAN, 3314 GLEN AVE. #21215

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIBUTING
CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Marvin S. Platt, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-1-72

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

8/1/72

24C. NAME of CEMETERY or CREMATORY

SHOMREI MISHMERES

24D. LOCATION (City, town, or county)

ROSEDALE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

AUG 4 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

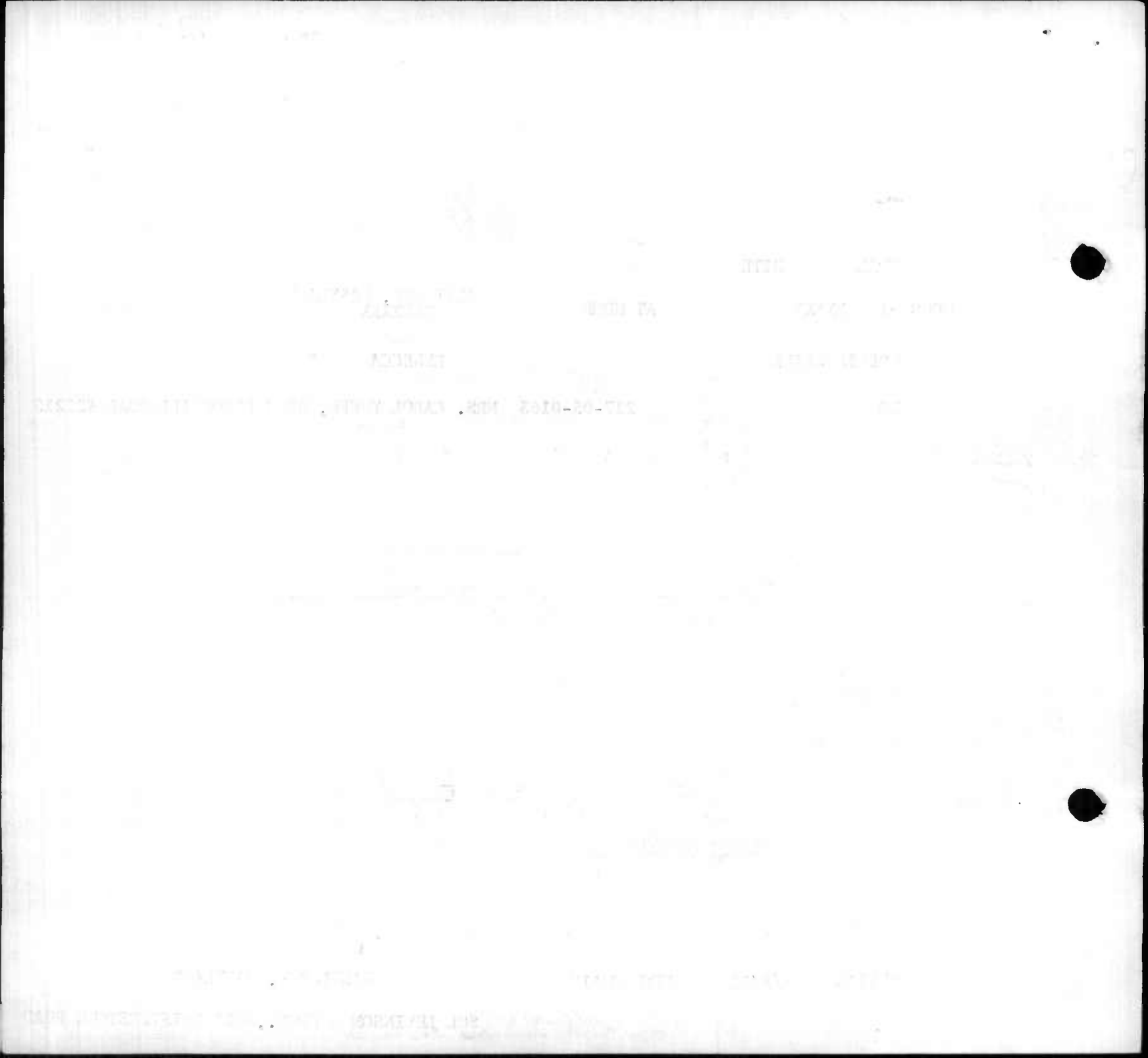
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD

9/2/12 - Naturalization Cert. Pet # 43390. No. 8337043.
Naturalized 12/14/1961. Date of birth: Oct. 25, 1913, spec.

FUNERAL DIRECTOR: IMPORTANT

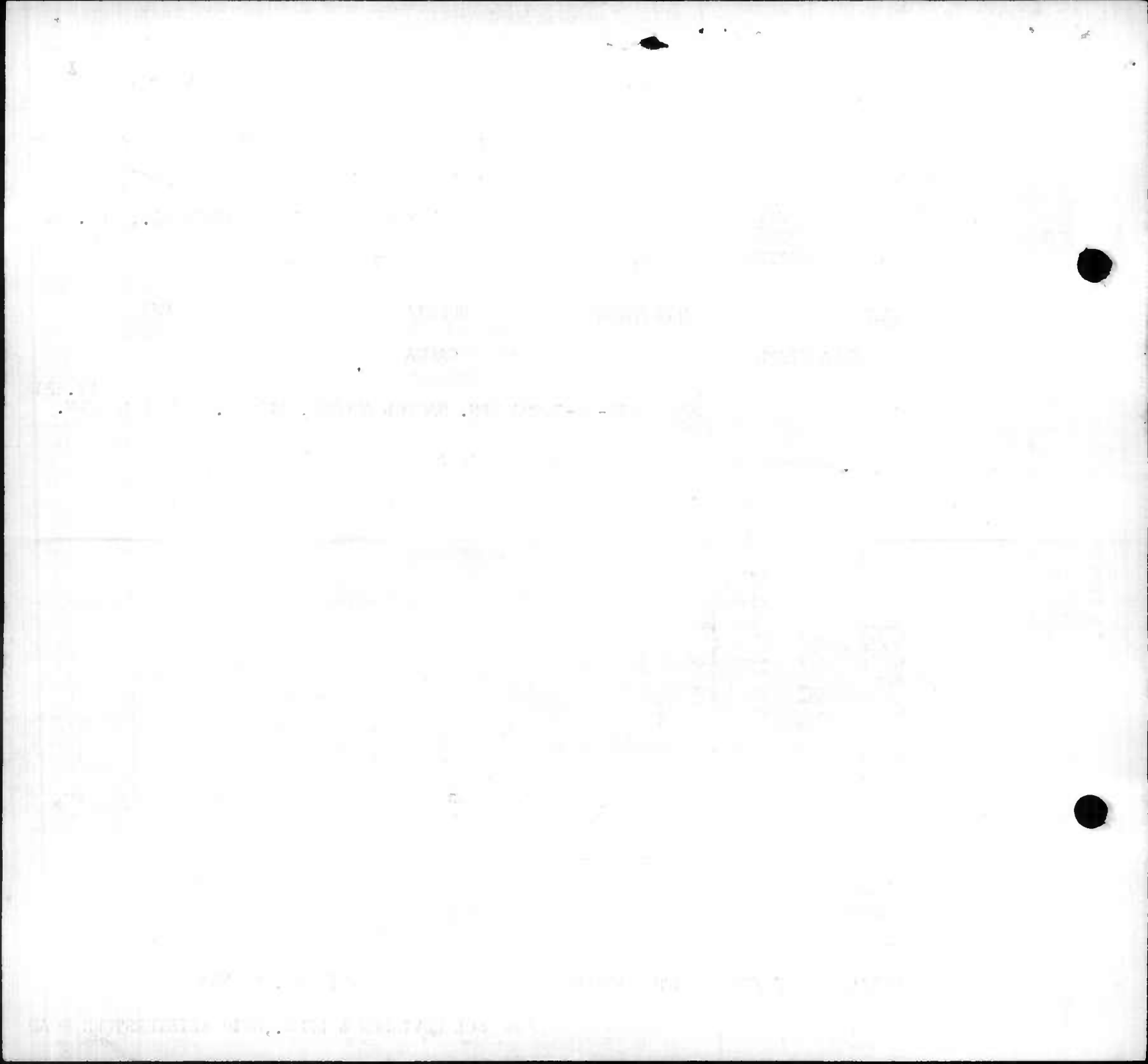
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 11- (106) | | 72 07417 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07417 | |
| BIRTH NO. | | | | REG. NO. | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Chmar, Ed. H.</i> | | | | 2. DATE AND HOUR OF DEATH <i>7/31/72 6:40 P.M.</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Univ. of Md. Hospital</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Balto.</i> | | | |
| 5. SEX <i>FEMALE</i> 6. RACE <i>WHITE</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH <i>7-19-11</i> 9. AGE (in years last birthday) <i>61</i> | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE XXXXX</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>AT-HOME</i> | | 11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, MARYLAND XXXXXX</i> | |
| 13. FATHER'S NAME <i>MORRIS BRILL</i> | | | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | | | 16. SOCIAL SECURITY NO. <i>217-05-0163</i> | | 17. INFORMANT ADDRESS <i>MRS. CAROL YOFFE, 6804 BROOKMILL ROAD #21215</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>174X I Metastatic Carcinoma of Breast</i> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>1956 →</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION <i>1956</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>CA Breast</i> | | 20A. AUTOPSY? (Yes or No) <i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Notify medical examiner <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>7-13</i> 19 <i>72</i> to <i>7/31</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>7/31</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Conrad E. Nagle, MD</i> | | | | 23B. DATE SIGNED <i>7/31/72</i> | | 23C. PHYSICIAN'S NAME (Type) <i>CONRAD E. NAGLE, MD</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | | | 24B. DATE <i>8/2/72</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>AITZ CHAIM</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>AUG 4 1972</i> | | | | 25B. NAME OF REGISTRAR <i>Adrienne Johnson</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</i> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07418 | | | |
|--|--|------------------------|---|---|--|---|--|
| 72-07418 | | | | | | | |
| BIRTH NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | | | |
| JOSEPH BRAVE | | | 7-31-72 9:05 AM | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE B. COUNTY | | | | |
| SINAI Hospital of Baltimore | | | MARYLAND LEVINDALE NURSING H | | | | |
| 42 | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | | |
| BALTIMORE | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| E. STREET AND NUMBER | | | F. STREET AND NUMBER | | | | |
| XXXXXXX | | | 3607 LABYRINTH RD., APT. 2E | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | | |
| MALE | | WHITE | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | |
| AGENT | | | INSURANCE | | RUSSIA | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | | | |
| ABBA BRAVE | | | GAEDA | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| NO | | | 212-03-7689A | | MRS. SAMUEL ABRAMS, 1190 W. NORTHERN PKWY. APT. 621 | | |
| 18. CAUSE OF DEATH | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause, and the UNDERLYING CONDITION last. | | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II | | | | | (C) FRACTURE Rhip | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (A). | | | | | 20A. AUTOPSY? (Yes or No) | | |
| 19A. DATE OF OPERATION | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 17-12-72 | | | | | No | | |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | |
| FRACTURE Rhip | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | |
| LEVINDALE N.H. LEVINDALE N.H. | | | | | 7-15-72 | | |
| 21E. INJURY OCCURRED | | | | | 21F. HOW DID INJURY OCCUR? | | |
| While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | | | | Fell down on way to BATHROOM | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-15-72 to 7-31-72 and that (I) (we) lost saw the deceased alive on 7-31-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | | 23B. DATE SIGNED | | |
| Jose B. Corvera, M.D. | | | | | 7-31-72 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS | | |
| JOSE B. CORVERA, M.D. | | | | | SINAI HOSPITAL, BALTIMORE | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | | 8/2/72 | | BETH TFILOH | | BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| AUG 4 1972 | | Sol Levinson | | SOL LEVINSON & BROS. | | 6010 REISTERSTOWN ROAD | |



B-652

72 67419 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 67419

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) JOSEPH XXXXXXXXXX BORNSTEIN | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME AND HOSPITAL | | 3. DATE PRONOUNCED DEAD Month Day Year Hour July 31, 1972 3:42 P.M. | |
| 6. SEX Male | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| 9. DATE OF BIRTH MARCH 5, 1909 | | 10. AGE (In years last birthday) 63 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED | | 15. MOTHER'S MAIDEN NAME LENA BORDANSKY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 17. SOCIAL SECURITY NO. 218-09-5942 | |
| 18. INFORMANT MR. HARRY BORNSTEIN, 2904 TANEY RD., APT. 2A | | ADDRESS | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of chest | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| 22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION 7-31-72 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Loan Co. (Pawn) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 11 N. Caroline Street | |
| 22D. TIME OF INJURY (APPROX.) 7-31-72 3:34 P.M. | | 22E. HOW DID INJURY OCCUR? Shot during robbery | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 24. ACTUAL SIGNATURE Ronald N. Kornblum, M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 8/2/72 | |
| 24C. NAME OF CEMETERY or CREMATORY BNAI ISRAEL | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 4 1972 | | 25B. NAME OF REGISTRAR Adney W. Houston | |
| 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | ADDRESS | |

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

MARCH 2, 1968

12441 BOSTON

USA

BALTIMORE, MARYLAND

12441 BOSTON

PAID NUMBER

SELF REPORTED

SEE-OF-FILE T. HARRY BOSTON, FROM TWENTY IN...

NO

BALTIMORE, MARYLAND

12441 BOSTON

PAID

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

SEE-OF-FILE T. HARRY BOSTON, FROM TWENTY IN...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07420 | |
|--|-------------------------|---|---|--|--|
| <div style="display: flex; justify-content: space-between;"> 6-5211 72 07420 CERTIFICATE OF DEATH </div> <div style="text-align: center;">STATE OF MARYLAND-DEATH</div> | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| CLARA GINSBURG | | AUGUST 1, 1972 | | 12:15 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION PLEASANT MANOR NURSING HOME | | | A. STATE MARYLAND | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 90 | | | E. STREET AND NUMBER 5739 GREENSPRING AVENUE #21209 | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) 75 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) RUSSIA | |
| 13. FATHER'S NAME MANDEL FRIEDLAND | | | 14. MOTHER'S MAIDEN NAME RACHEL M NULURTSKY | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 143-42-9087 | | 17. INFORMANT ADDRESS MRS. THEODORE FELDBERG, 5739 GREENSPRING AVE. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 41231x2509 ACUTE MYOCARDIAL INFARCTION | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 weeks (acute myocardial) | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetic mellitus, generalized arteriosclerosis | | | 3 years | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from Dec 19 69 to 1 Aug 1972 , that (I) (we) last saw the deceased alive on 31 July 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE MADame | | | | 23B. DATE SIGNED 1 Aug 1972 | |
| 23C. PHYSICIAN'S NAME (Type) MARVIN DAVIS | | | | 23D. ADDRESS 8507 LIBERTY ROAD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL-BURIAL | | 24B. DATE 8/2/72 | | 24C. NAME OF CEMETERY or CREMATORY REISN HUVIN CEMETERY | |
| 24D. LOCATION (City, town, or county) (State) NEWARK, NEW JERSEY | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 4 1972 | | 25B. NAME OF REGISTRAR Adelmy to hoston | | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | |

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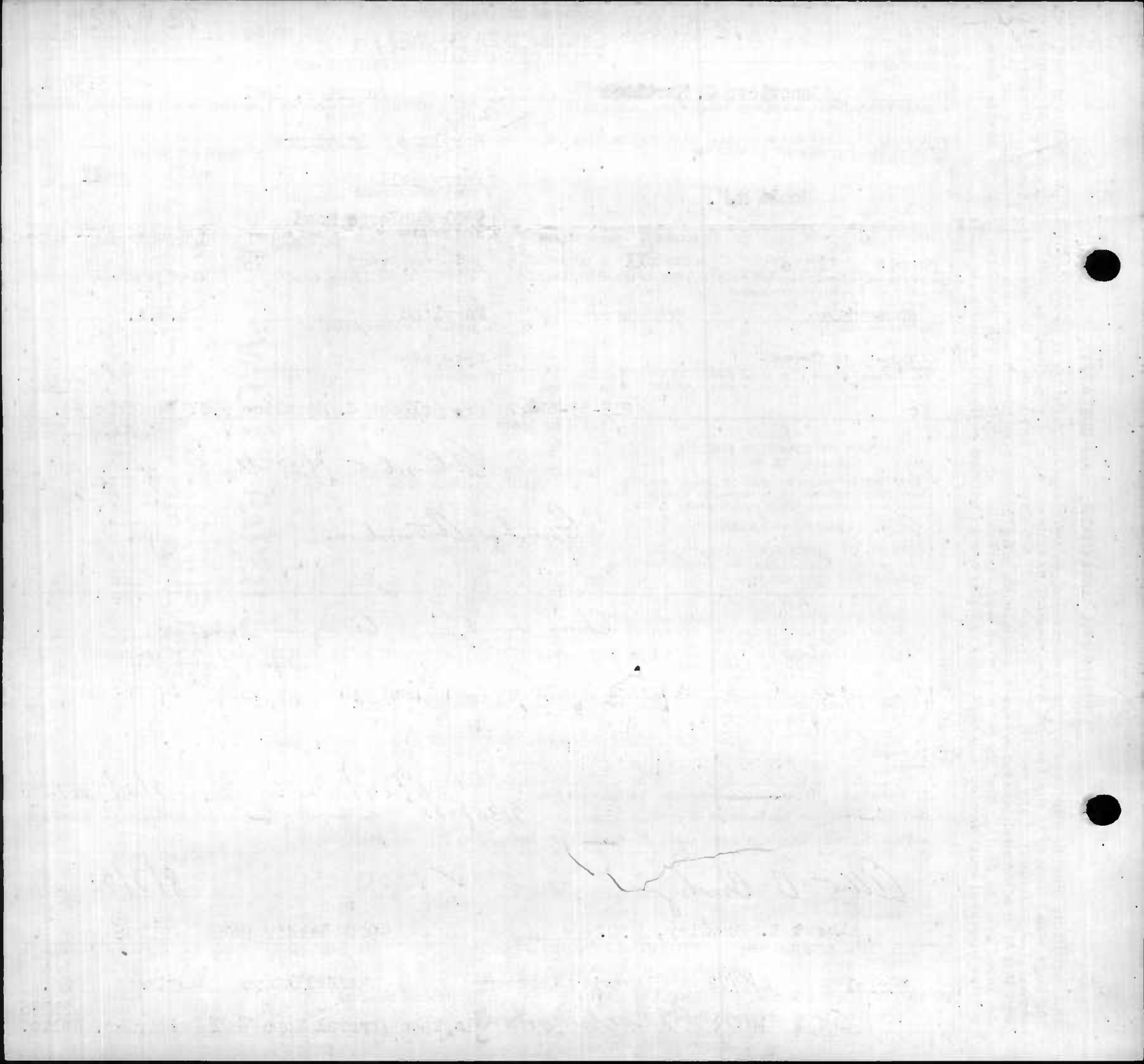
11-11-11

11-11-11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|--|--|--|
| <p>72 07421</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p> <p>STATE OF MARYLAND-DEMH</p> | | <p>REG. NO. 72 07421</p> | |
| BIRTH NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | August 2, 1972 3:50 A.M. | |
| Genevieve C. Hartlieb | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | |
| 90 Gould N.H. | | Maryland Baltimore | |
| | | C. CITY OR TOWN D. INSIDE CITY LIMITS? | |
| | | Perry Hall YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | E. STREET AND NUMBER | |
| | | 9901 Gunforge Road | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH |
| Female | White | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | July 20, 1897 75 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 9. AGE (In years last birthday) | |
| Housewife | | 75 | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Homemaker | | Maryland | |
| 13. FATHER'S NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Gilbert J. Hughes | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| No | | 215-03-6722A | |
| | | 17. INFORMANT ADDRESS | |
| | | Mr. Gilbert J. Hartlich 9901 Gunforge Rd. 21128 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES | | Arteriosclerotic Heart Disease you | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Generalized Arteriosclerosis you | |
| | | (C) _____ | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | |
| Chronic Brain Syndrome. Old Myocardial Infarction. | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| | | | |
| 22. I certify that (I) (the hospital) attended the deceased from 11/24/1970 to 8/2/1972, that (I) (we) last saw the deceased alive on 7/30/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | |
| Albert B. Bradley | | 8/2/72 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | |
| Albert B. Bradley, M.D. | | 4900 Belair Road 21206 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) |
| Burial | 8/4/72 | Lakeview Cemetery | Randallstown Baltimore Md. |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR ADDRESS | |
| AUG 4 1972 | Sidney B. Borker | Lassahn Funeral Home 7401 Belair Rd. Balto. 21236 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|------------------------------|--|
| P-5521 | | 72 07422 | | BALTIMORE CITY HEALTH DEPARTMENT | | X | | REG. NO. | | 72 07422 | |
| <div style="text-align: center;"> CERTIFICATE OF DEATH STATE OF MARYLAND-DEMH </div> | | | | | | | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| | | John Daniel Pennington | | | | 8/1/72 11:35 A | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | | | A. STATE B. COUNTY | | | | | |
| University of Maryland Hospital 38 | | | | | | Md. Washington 7100 | | | | | |
| C. CITY OR TOWN | | | | | | D. INSIDE CITY LIMITS? | | | | | |
| Williamsport | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| E. STREET AND NUMBER | | | | | | | | | | | |
| RFD # 2 | | | | | | | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (in years last birthday) | | 10. Under 1 Yr. Months Days | |
| M | | W | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 10/15/64 | | 7 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| None | | | | None | | | | Maryland | | U.S.A. | |
| 13. FATHER'S NAME | | | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| Nova W. Pennington | | | | | | Lola Marlene Jordan | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | | | None | | 1033D Noland Dr. Mrs Marlene Pennington, Hagerstown, Md. | | | | | |
| 18. CAUSE OF DEATH | | | | | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | | | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | | | | | | | |
| ANTECEDENT CAUSES | | | | | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Obstructive Pulmonary Disease 2° Bronch - 15% and Regenerative </div> <div> (B) DUE TO, OR AS A CONSEQUENCE OF: Cerebral Edema </div> <div> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months </div> </div> | | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | | | |
| 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> 21F. HOW DID INJURY OCCUR? | | | | | | | | | | | |
| 6-3-72 3 A Home RFD #2 power line | | | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/3/72 to 8/1/72 that (I) (we) last saw the deceased alive on 8/1/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE | | | | | | 23B. DATE SIGNED | | | | | |
| J.H. Ziegler M.D. | | | | | | 8/1/72 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | 23D. ADDRESS | | | | | |
| J.H. Ziegler M.D. | | | | | | University of Maryland Hospital | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | 8-4-72 | | Greenlawn Cemetery | | | | Williamsport, Wash., Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | | | 25C. FUNERAL DIRECTOR ADDRESS | | | |
| AUG 4 1972 | | | | Audrey [Signature] | | | | Albert L. Leaf, Williamsport, Md. | | | |

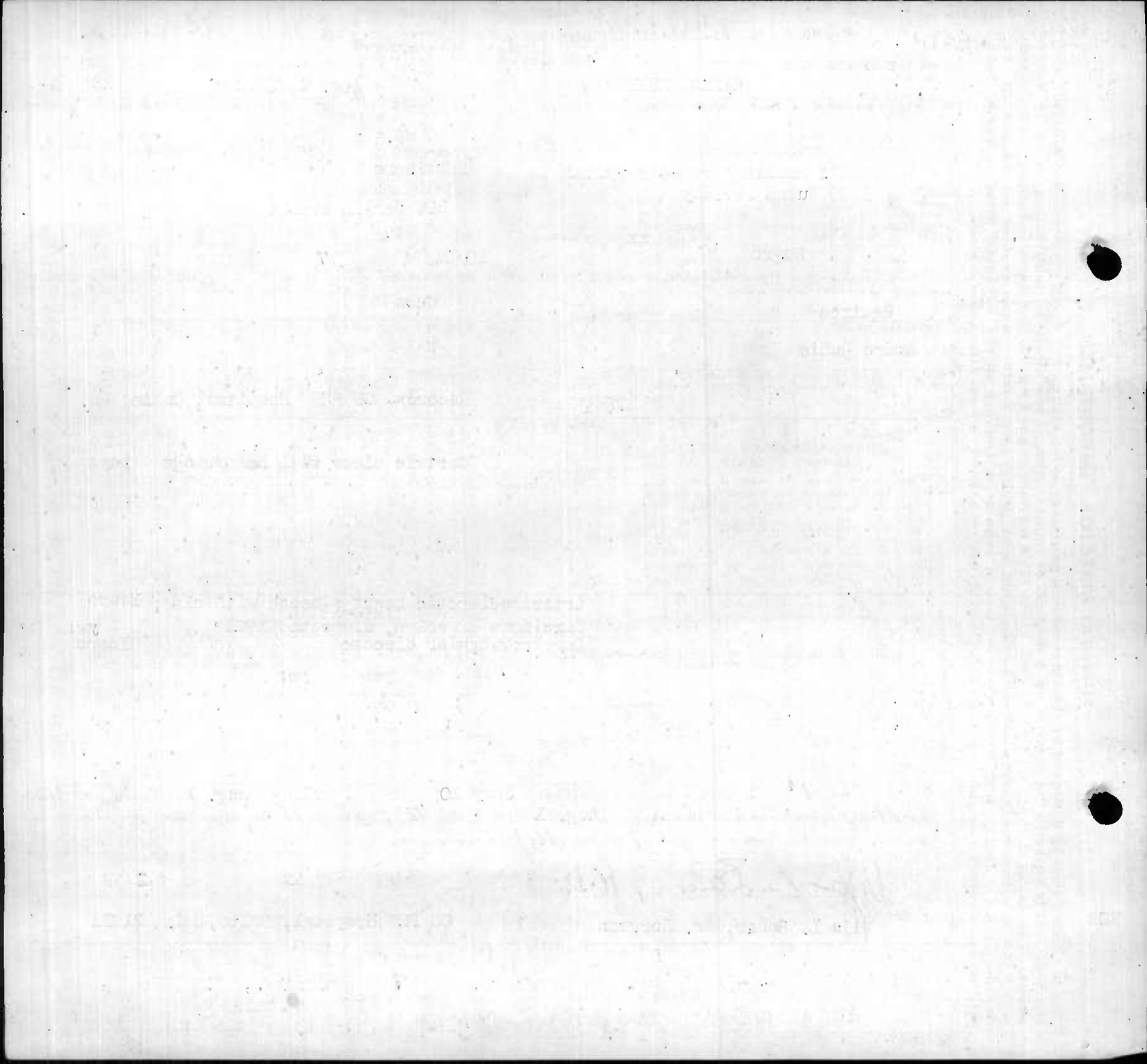
Handwritten signature

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|--|--|
| 72 07423 CERTIFICATE OF DEATH | | | | | | | | | | | |
| STATE OF MARYLAND-DEMD | | | | | | | | | | | |
| REG. NO. 72 07423 | | | | | | | | | | | |
| BIRTH NO. | | | | 1 | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | RAFAEL RUBIE | | | | 2. DATE AND HOUR OF DEATH Aug. 1, 1972 10 A M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY BALTO | | | | 5. CITY OR TOWN Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital 2X 3100 Wuman Parkway | | | | 6. DATE OF BIRTH 10/24/94 | | | | 7. AGE (In years last birthday) 77 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) Cuba | | | |
| 13. FATHER'S NAME Andre Rubie | | | | 14. MOTHER'S MAIDEN NAME ? | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ? | | | | 16. SOCIAL SECURITY NO. 219032467A | | | | 17. INFORMANT Catherine Rubie Records- US PHS Hospital, Balto, Md. | | | |
| 18. 531.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Gastric ulcer with hemorrhage | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Arteriosclerotic heart disease with old infarct Carcinoma of colon, dissected 1971 Cerebrovascular disease | | | | Years | | | | 1 yr. Years | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 10 1972 to Aug. 1 1972, that (I) (we) last saw the deceased alive on Aug. 1 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Vija L. Bauer, H.D. | | | | | | | | 23B. DATE SIGNED 8/2/72 | | 23C. PHYSICIAN'S NAME (Type) Vija L. Bauer, Sr. Surgeon | |
| 23D. ADDRESS US PHS Hospital, Balto, Md. 21211 | | | | | | | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-5-72 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem. | | | | | | | | 24D. LOCATION (City, town, or county) (State) Balto., Md. | | 25A. DATE REC'D BY HEALTH DEPT. AUG 4 1972 | |
| 25B. NAME OF REGISTRAR A. Bailey | | | | | | | | 25C. FUNERAL DIRECTOR V. Bailey | | ADDRESS 1348 Calhoun Street | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 72 07424 BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07424 | |
|---|---------|--|---|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Cannon, Robert | | 8/1/72 11:10 p.m. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | A. STATE B. COUNTY | | |
| IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | | Maryland | | |
| 33 The Johns Hopkins Hospital | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? |
| | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER | | |
| | | | 1550 Lesley Street | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| Male | Negro | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 10/04/05 | 66 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| | | | Md. | | U.S.A. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Tombert Anderson | | | Rachel Cannon | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | Helen Cannon same | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | | |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Probable myocardial infarction.</u> | | | | | |
| (B) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (C) <u>COPD</u> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| <u>DID RIGHT Hemiparesis</u> | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 1 Month 1 Day 1 Year 1 Hour | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7/30</u> 19 <u>72</u> to <u>8/1</u> 19 <u>72</u> that (H) (we) last saw the deceased alive on <u>8/1</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| <u>Frederick M. Wigley, M.D.</u> | | | | 8/1/72 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Frederick M. Wigley, M.D. | | | | The Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 8-5-72 | | Mt. Auburn Cem. | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| | | | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| AUG 4 1972 | | <u>Andrew Johnston</u> | | V. Bailey 1348 Calhoun St. | |

10/10/1913

10/10/1913

10/10/1913

10/10/1913

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 72 07425
STATE OF MARYLAND-DEMH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Riddix Ernest

2. DATE AND HOUR OF DEATH

August 1, 1972, 7:40 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
200 Liberty Height Ave.

9 Provident Hosp.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Md. Balt.

1510

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

4001 Maine Ave.

5. SEX

M

6. RACE

N

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

4-28-09

9. AGE (in years last birthday)

63

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

USA.

13. FATHER'S NAME

Wm. Riddix

14. MOTHER'S MAIDEN NAME

JoAnne Watkins

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

212-09-15-61

17. INFORMANT

Adverta Riddix (WIFE) SAME

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Gastrointestinal hemorrhage

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Sickle cell

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Sickle cell Thalassemia

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 18, 1972, to Aug. 1, 1972, that (I) (we) last saw the deceased alive on Aug. 1, 1972, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

V. Chitrappee

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

Aug. 1, 1972

23C. PHYSICIAN'S NAME (Type)

V. Chitrappee

23D. ADDRESS

Provident Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-7-72

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cemetery

24D. LOCATION

Baltimore, Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 4 1972

25B. NAME OF REGISTRAR

Andrew H. Hoston

25C. FUNERAL DIRECTOR

V. Bailey

ADDRESS

Kelson T.H. 1348 Calhoun Street

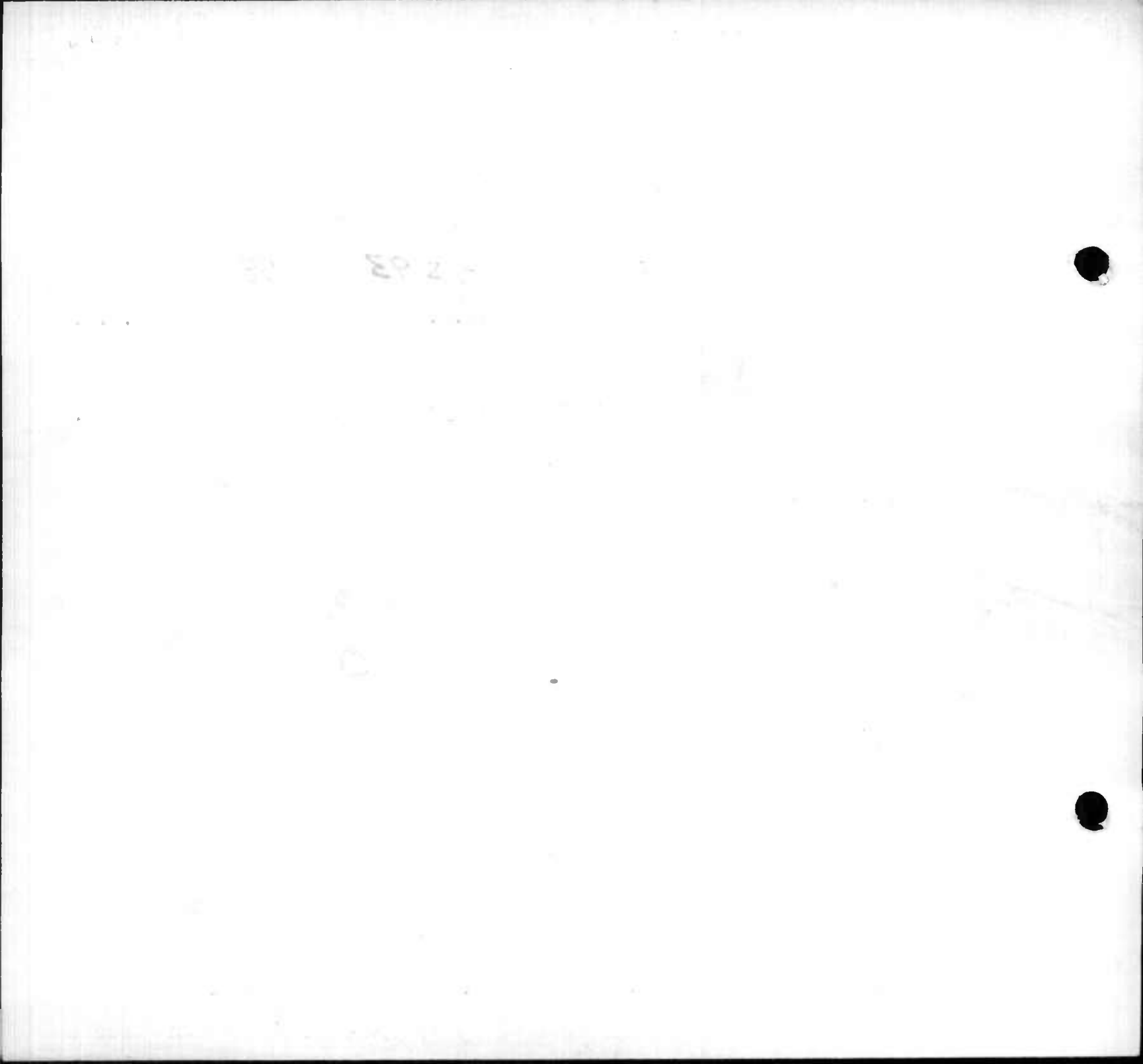
26

PO-85

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 72 07426 BALTIMORE CITY HEALTH DEPARTMENT | | 72 07426 | |
|--|---|---|--|
| CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) CHAMBERS ALLISON | | 2. DATE AND HOUR OF DEATH 8-1-72 12:10 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital of Maryland 46 | | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE Md. B. COUNTY 1501 C. CITY OR TOWN Balt. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1408 Vincent St. | |
| 5. SEX male | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-18-93 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Barber | 9. AGE (In years last birthday) 78 |
| 11. BIRTHPLACE (State or foreign country) S.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 220300344A | |
| 17. INFORMANT James Chambers | | ADDRESS 2754 Ellicott Dr. | |
| 18. 039.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE SEPTIC SHOCK. DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION 0 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-5-1972 to 8-1-1972 that (I) (we) last saw the deceased alive on 8-1-1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Shaf Abdul M.D. | | 23B. DATE SIGNED 8-1-72 | |
| 23C. PHYSICIAN'S NAME (Type) JAWED H. SIDDIQI M.D. | | 23D. ADDRESS Lutheran Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 8-5-72 | 24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem. | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 4 1972 | 25B. NAME OF REGISTRAR Andrew L. Kelson | 25C. FUNERAL DIRECTOR V. Bailey | ADDRESS 1348 Calhoun Street |



STATE OF MARYLAND - DEMO
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|--|---|--|
| BIRTH NO. | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) DELORES A. HAIRSTON | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2110 N. Calvert Street | | 3. DATE PRONOUNCED DEAD Month Day Year Hour August 2, 1972 7:35 A.M. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1204 | | 6. SEX Female 7. RACE Negro 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH 3/28/48 10. AGE (In years last birthday) 24 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U S A | | E. STREET AND NUMBER 2110 N. Calvert Street | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic 14B. KIND OF BUSINESS OR INDUSTRY | | 13. FATHER'S NAME Theodore Upshur | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no 17. SOCIAL SECURITY NO. | | 15. MOTHER'S MAIDEN NAME Fannie Mae | |
| 18. INFORMANT Rev Mathew Moreland, 801 Resvoir St | | 19. 571.81 + 5929X CAUSE OF DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) Subdural Hematoma | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE Fatty metamorphosis of liver DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Subdural hematoma Fatty metamorphosis of liver | | | |
| 20A. DATE OF OPERATION 2/1 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unk. | |
| 22C. WHERE DID INJURY OCCUR? Unk. | | 22D. TIME (Month) (Day) (Year) (Hour) (Approx.) Unknown | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> ? NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Unk? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Marvin S. Platt M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Marvin S. Platt, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/8/72 | |
| 24C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetry | | 24D. LOCATION (City, town, or county) (State) Baltimore, M. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 4 1972 | | 25B. NAME OF REGISTRAR Adolphus Halstead | |
| 25C. FUNERAL DIRECTOR Adolphus Halstead | | ADDRESS 1206 W North Ave | |

8-25-1972- Letter from the Office of the Chief Medical Examiner,
Marvin S. Platt, M.D., Assistant Medical Examiner HRS

8-30-1972 - Letter from the Office of the Chief Medical Examiner,
Marvin S. Platt, M.D., Assistant Medical Examiner HRS

1
C-430STATE OF MARYLAND
BALTIMORE CITY HEALTH DEPARTMENT

72 07428

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

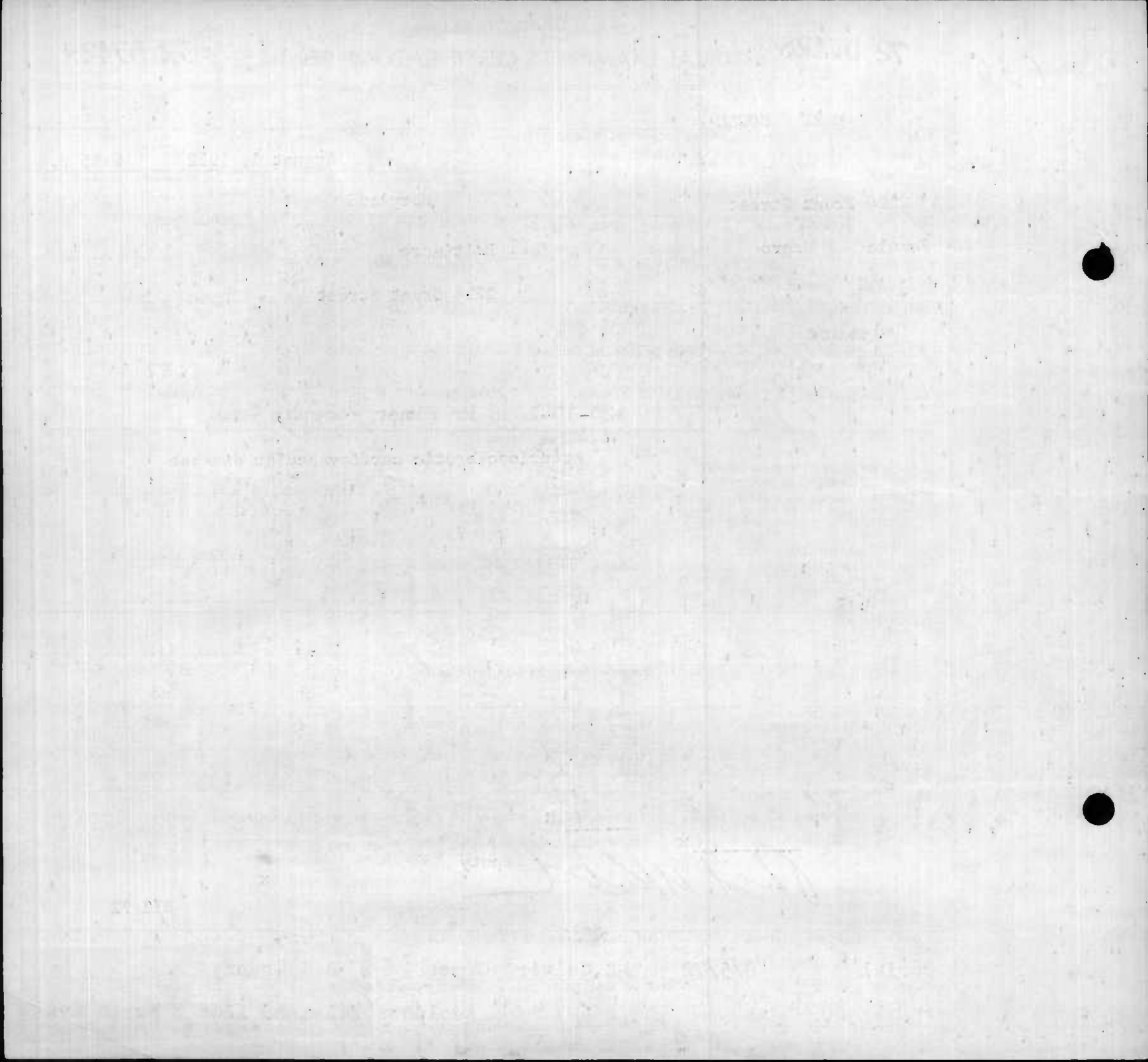
REG. NO.

72 07428

BIRTH NO.

| | | | |
|--|---|---|-------------------------------------|
| 1. NAME OF DECEASED (Type or Print) MARY GOULD | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2224 Brunt Street | | 3. DATE PRONOUNCED DEAD Month Day Year Hour August 1, 1972 6:55 P.M. | |
| 6. SEX Female | 7. RACE Negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN Baltimore |
| 9. DATE OF BIRTH 1908 | 10. AGE (In years last birthday) 64 | E. STREET AND NUMBER 2224 Brunt Street | |
| 11. BIRTHPLACE (State or foreign country) Deleware | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. 220-30-1088 | |
| 18. INFORMANT Mr Elmer Joseph, Smae | | ADDRESS | |
| 19. 7124 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | |
| 20A. DATE OF OPERATION 8/5/72 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE [Signature] Deputy CHIEF MEDICAL EXAMINER EXAMINER'S NAME (Type) [Signature] ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/7/72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/5/72 | |
| 24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery | | 24D. LOCATION (City, town, or county) (State) A A County Md | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 4 1972 | | 25B. NAME OF REGISTRAR Sidney [Signature] | |
| 25C. FUNERAL DIRECTOR Adolphus Halstead | | ADDRESS 1206 W North Ave | |

19720003424



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPT. | | | | REG. NO. 72 07429 | |
|---|-------------------|--|-----------------------------------|--|---|
| BIRTH NO. 72 07429 | | | | CERTIFICATE OF DEATH | |
| STATE OF MARYLAND - DEPT. | | | | DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) LEONARD, ROBERT | | 2. DATE AND HOUR OF DEATH 8/1/72 6:45 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY AA C. CITY OR TOWN Glen Burnie D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Cooper Convalescent Home Bldg 476 | | | |
| 5. SEX M | 6. RACE B. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-20-1902 | 9. AGE (In years last birthday) 69 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY Construction | | 11. BIRTHPLACE (State or foreign country) West River Md. | |
| 13. FATHER'S NAME Robert Leonard Sr. | | 14. MOTHER'S MAIDEN NAME Mariah Foote | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220-072888A | | 17. INFORMANT Esther Sanderson ADDRESS St Albans N.Y. 115-73 203rd St. | |
| 18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CONGESTIVE HEART FAILURE (B) Arteriosclerotic cardiovascular disease (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION nil | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED nil | | 20A. AUTOPSY? (Yes or No) nil | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) nil | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) nil | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) nil | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) nil | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? nil | |
| 22. I certify that (X) (this hospital) attended the deceased from 8/1/72 to 8/1/72 , that (I) (X) last saw the deceased alive on 8/1/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE R. Sirthara | | M.D. M.D. | | 23B. DATE SIGNED 8/1/72 | |
| 23C. PHYSICIAN'S NAME (Type) SIRITHARA | | 23D. ADDRESS SOUTH BALTIMORE GENERAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/5/72 | | 24C. NAME OF CEMETERY OR CREMATORY Franklin Chapel Cem. Churchton Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 4 1972 | | 25B. NAME OF REGISTRAR William W. ... | | 25C. FUNERAL DIRECTOR William W. ... ADDRESS 3197 ... | |

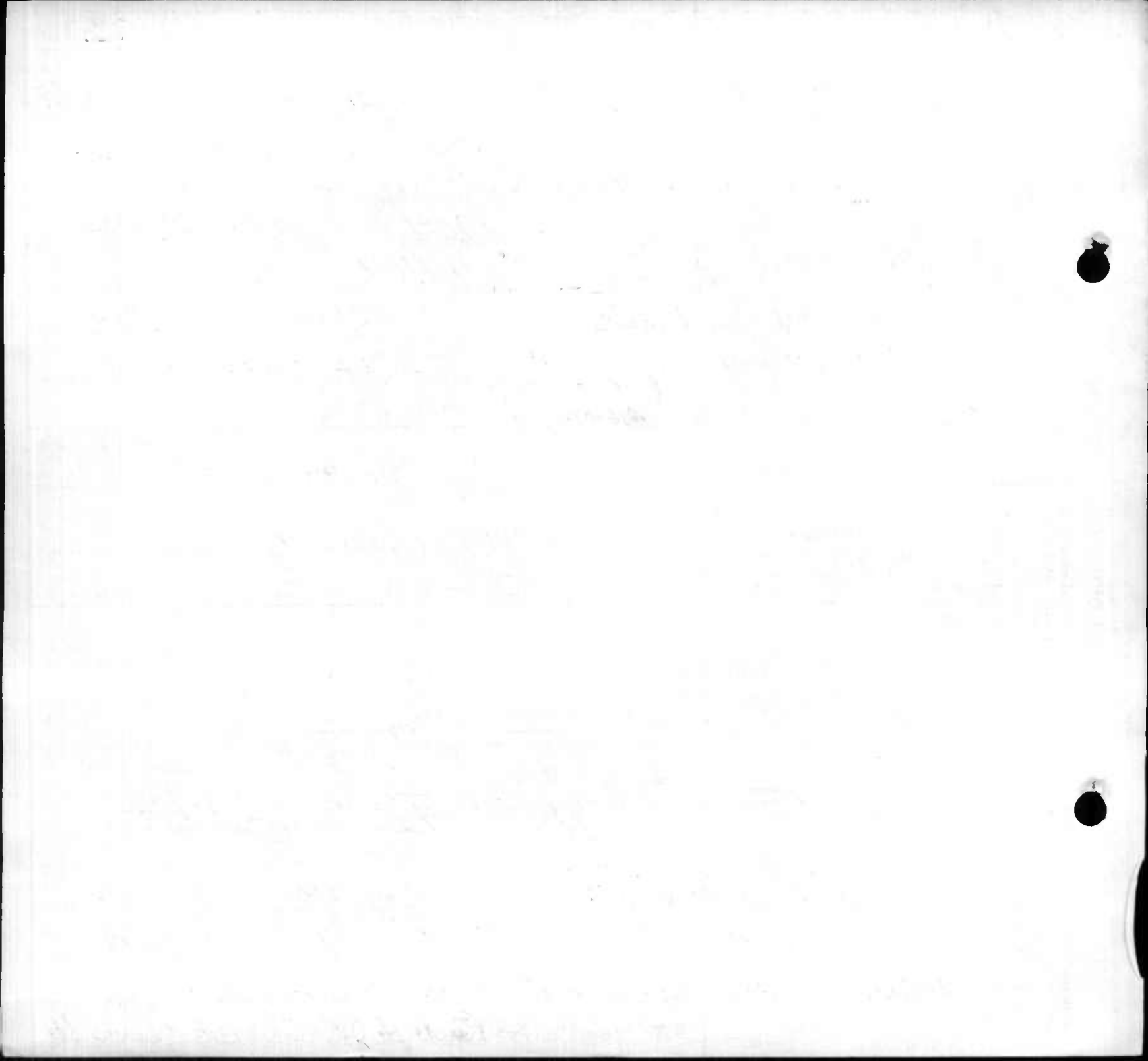
11/16/70 - Adm.

Prev. address 7150 N. H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT 72 07430 | | 72 07430 | |
|---|--|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | REG. NO. | |
| ALSTON, WILLIE | | 7/31/72 | | 11:35 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | 5. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | MD. BALTIMORE | | 806 | |
| THE JOHNS HOPKINS HOSPITAL | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| 33 | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER | | 1704 N. CHAPEL ST., MD. | | | |
| 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| M NEGRO | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 2/14/04 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday) | |
| CHAUFFEUR | | PUBLIC | | 69 | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 11. BIRTHPLACE (State or foreign country) | |
| UNKNOWN | | ELIZA (UNKNOWN) | | S. CAROLINA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 12. CITIZEN OF WHAT COUNTRY? | |
| YES ARMY, WWII | | 216-01-9079 | | USA | |
| 18. CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) IMMEDIATE CAUSE | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CARDIAC ARREST | | | |
| ANTECEDENT CAUSES | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) ? RECURRENT PULMONARY EMBOLI | | | |
| (C) ? TBC | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| NO | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | |
| 21F. HOW DID INJURY OCCUR? | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21G. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/31/72 19 to 7/31/72 19 that (I) (we) lost saw the deceased alive on 7/31 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) | |
| NEILL S. HIRST MD | | 7/31/72 | | NEILL S. HIRST MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| BURIAL | | 8-5-72 | | MT. CALVARY CEMETERY | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| AUG 4 1972 | | Audrey M. Dwyer | | P. BRUNDEL CO., MD. | |
| 25D. ADDRESS | | 25E. ADDRESS | | | |
| 2431 E. OLIVER ST. | | 2431 E. OLIVER ST. | | | |



H-525

BALTIMORE CITY HEALTH DEPARTMENT

72 07431

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07431

BIRTH NO. STATE OF MARYLAND-DHMH

| | | | |
|--|---|---|--|
| 1. NAME OF DECEASED (Type or Print) MARY E. HENSON | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 PROVIDENT HOSPITAL | | 3. DATE PRONOUNCED DEAD Month Day Year Hour August 1, 1972 3:02 P.M. | |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1513 | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 6. SEX Female | 7. RACE Negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH AUG. 13, 1906 | 10. AGE (In years last birthday) 65 | 11. BIRTHPLACE (State or foreign country) Towson, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME UNKNOWN | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 14B. KIND OF BUSINESS OR INDUSTRY Domestic | |
| 15. MOTHER'S MAIDEN NAME UNKNOWN | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | |
| 17. SOCIAL SECURITY NO. 215 18 6309 | | 18. INFORMANT ADDRESS Mary L Pulley 2454 Keyworth Ave. | |
| 19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION 8/5/72 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) no | | 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. | | Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/2/72 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/5/72 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 4 1972 | | 25B. NAME OF REGISTRAR Sidney W. Gwynn | |
| 25C. FUNERAL DIRECTOR LEWIS T GWYNN | | ADDRESS 4517 PARK HEIGHTS AVE. | |

1711

AUG. 15, 1906

UNION

1906

Twelve, New York

UNION

1906

Twelve, New York

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WALLACE

1906

1906

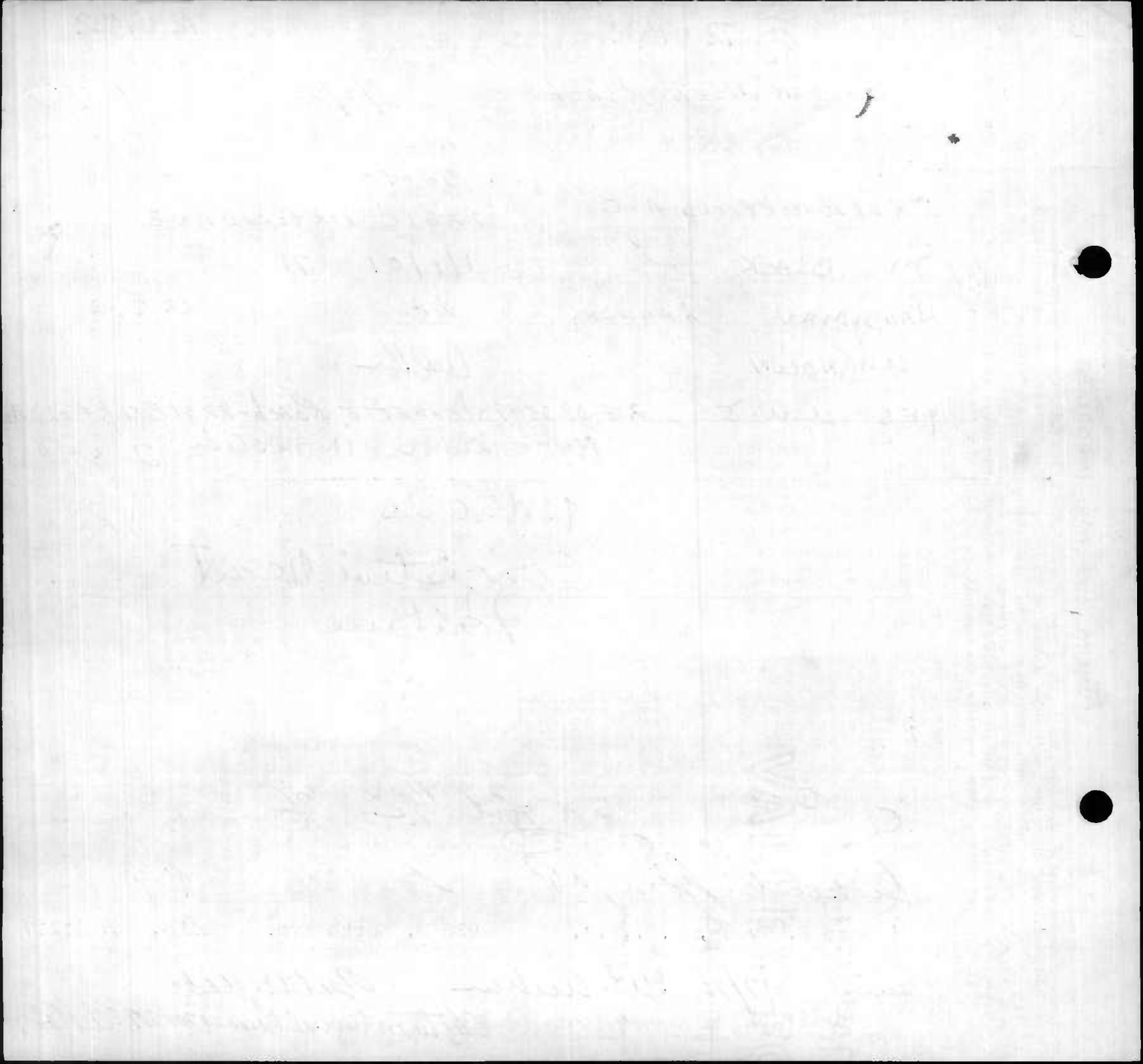
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FUNERAL DIRECTOR: IMPORTANT

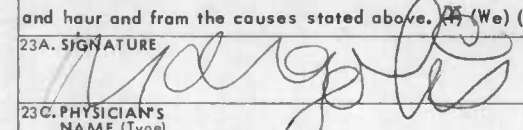
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07432 | | REG. NO. 72 07432 | |
|--|-------------------------|---|---|---|---|---|---|
| 72 07432 | | | | STATE OF MARYLAND - DEMO | | | |
| 1. NAME OF DECEASED (Type or Print) JASPER ALLEN ROACH | | | | 2. DATE AND HOUR OF DEATH 8/3/72 1:00 P. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY 1302 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 00 | | | | C. CITY OR TOWN BALTO. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2231 BROOKFIELD AVE. | | | | E. STREET AND NUMBER 2231 BROOKFIELD AVE | | | |
| 5. SEX M | 6. RACE BLACK | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/10/71 | 9. AGE (In years last birthday) 71 | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HANDYMAN | | | 10B. KIND OF BUSINESS OR INDUSTRY LAUNDRY | | 11. BIRTHPLACE (State or foreign country) V.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME UNKNOWN | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.I. | | | 16. SOCIAL SECURITY NO. 218-02-2549 | | 17. INFORMANT JEANETTE ROACH-2231 BROOKFIELD AVE. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 4/10/01 MYOCARDIAL INFARCTION | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 HRS. | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II CONGESTIVE HEART FAILURE | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCUS (B) DUE TO, OR AS A CONSEQUENCE OF: CONGESTIVE HEART FAILURE (C) FAILURE | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 28 Nov 1969 to 28 Nov 1972 and that (2) (we) last saw the deceased alive on 28 Nov 1972 and that (3) (our) opinion of death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Richard F. Tyson, M.D., P.A. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 8-8-72 | |
| 23C. PHYSICIAN'S NAME (Type) Richard F. Tyson, M.D., P.A. | | | | 23D. ADDRESS 936 W. North Ave. Balto. Md. 21217 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/7/72 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 4 1972 | | 25B. NAME OF REGISTRAR Sydney Johnston | | 25C. FUNERAL DIRECTOR Johnston Funeral Home - 1701 N. Calver St | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>72 07433</u> | |
|---|-------------------------|--|------------------------------------|---|---|
| 72 07433 | | | | STATE OF MARYLAND-DMH | |
| BIRTH NO. | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>WAGNER, HENRY FREDERICK JR.</u> | | 8/3/72 7:30P. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1903</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>VETERANS ADMINISTRATION HOSPITAL</u> <u>3900 LOCH RAVEN BLVD</u> <u>BALTIMORE, MARYLAND 21218</u> | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER <u>1723 WEST PRATT STREET</u> | | | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6/24/09</u> | 9. AGE (In years last birthday) <u>63</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POSTAL EMPLOYEE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | |
| 13. FATHER'S NAME <u>HENRY WAGNER</u> | | 14. MOTHER'S MAIDEN NAME <u>MARY MEADES</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>12-7-43 to 5-1-44</u> | | 16. SOCIAL SECURITY NO. <u>217 20 65 21</u> | | 17. INFORMANT <u>CLINICAL RECORDS-VAN BALTO MD.</u> | |
| 18. <u>5710</u> I | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE <u>PROBABLE HEPATIC COMA</u> DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> | |
| (B) <u>CHRONIC HEPATIC DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF: | | (C) <u>ALCOHOLISM</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>SHOCK, ANURIA</u> | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <u>10</u> (this hospital) attended the deceased from <u>8-2-</u> 19 <u>72</u> to <u>8-3-</u> 19 <u>72</u> , that <u>10</u> (We) last saw the deceased alive on <u>8-3-</u> 19 <u>72</u> and that in <u>(We)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>10</u> (We) (did) <u>(not)</u> view the body after death. | | | | | |
| 23A. SIGNATURE  | | 23B. DATE SIGNED <u>8-4-72</u> | | 23C. PHYSICIAN'S NAME (Type) <u>KENNETH MARGOLIS, M. D.</u> | |
| 23D. ADDRESS <u>Veterans Administration Hospital</u> <u>3900 Loch Raven Blvd., Baltimore, Md. 21218</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>8/7/72</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Louder Park Cem.</u> | |
| 24D. LOCATION <u>Baltimore, MD.</u> | | 24E. DATE REC'D BY HEALTH DEPT. <u>AUG 7 1972</u> | | | |
| 25A. NAME OF REGISTRAR <u>Frederick J. ...</u> | | 25B. NAME OF REGISTRAR <u>Frederick J. ...</u> | | 25C. FUNERAL DIRECTOR <u>2101 Federal Ave</u> | |
| 25D. ADDRESS <u>Beth Md.</u> | | | | | |

Final 9/1/72
Baltimore Port Com. Baltimore
Final 9/1/72

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 72 07434 BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07434 | |
|---|---------|--|---|--|--|
| STATE OF MARYLAND-DEHM | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | EUNORA PRESTON | | 8/2/72 6 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | A. STATE B. COUNTY | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | Maryland | | |
| Residence: | | | C. CITY OR TOWN | | |
| 00 105 East 32nd. St. | | | Baltimore | | |
| | | | D. INSIDE CITY LIMITS? | | |
| | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | E. STREET AND NUMBER | | |
| | | | 105 E. 32nd. St. 21218 | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| FEMALE | WHITE | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | May 17, 1880 | 92 | Retired Teacher |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| College/High Sch. | | | Leipzig, Germany | | USA |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Orrin P. Maxson, M.D. | | | Kate Irene Sherman | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT: Son ADDRESS |
| NO | | | 217-48-9768 | | Walter M. Preston, 105 E. 32nd. St., City |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| II | | | Cerebral thrombosis | | 1 wk. |
| ANTECEDENT CAUSES | | | (A) IMMEDIATE CAUSE | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | Arteriosclerosis, cerebral | | 5 yr. |
| | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | Arteriosclerosis, generalized | | 15 yr. |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (the physician) attended the deceased from 8/2/72 to 8/2/72 that (I) (we) last saw the deceased alive on 7/29 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| W. R. Freeman JR MD. | | | | 8/3/72 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| W. R. Freeman JR MD. | | | | 1114 29th St, Baltimore, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| CREMATION | | 8/3/72 | | Security Process, Inc. | |
| | | | | Catonsville, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| AUG 7 1972 | | Sidney H. Stewart | | STEWART & MOWEN CO. 108 W. North Av. | |

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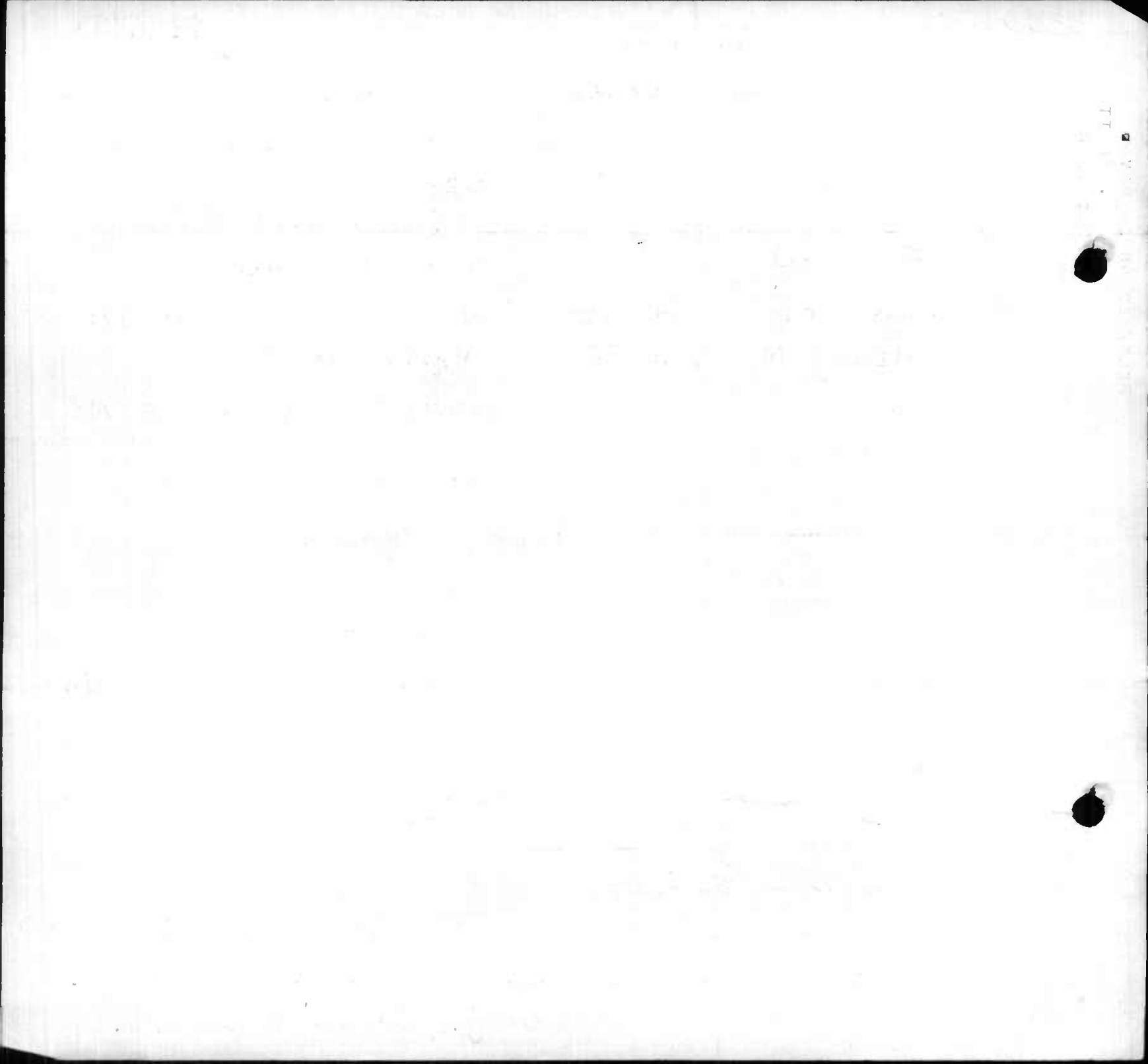
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 72 07435 | | BALTIMORE CITY HEALTH DEPARTMENT | | X REG. NO. 72 07435 | |
|--|------------------|---|--------------------------------|---|---|
| CERTIFICATE OF DEATH | | | | STATE OF MARYLAND-DHMH | |
| 1. NAME OF DECEASED (Type or Print) CONSTANCE SEGER | | 2. DATE AND HOUR OF DEATH 8-2-72 1815 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION GOOD SAMARITAN HOSPITAL IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 45 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY PRO GEORGE'S C. CITY OR TOWN BOWIE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 8500 SOLAR AVE | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-6-32 | 9. AGE (in years last birthday) 40 | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY HOME | | 11. BIRTHPLACE (State or foreign country) MISSOURI | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME HENRY M. SCHAFF | | | |
| 14. MOTHER'S MAIDEN NAME HAZEL RIEFFER | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT SAMUEL T. SEGER ADDRESS BOWIE, MD | | | |
| 18. 725X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE CARDIOMYOPATHY DUE TO, OR AS A CONSEQUENCE OF: (B) PRIMARY DYALOSIS DUE TO, OR AS A CONSEQUENCE OF: (C) CHRONIC UREMIA | | | |
| 19. DATE OF OPERATION 7-25-72 | | 19A. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-25-1972 to 8-2-1972 that (I) (we) last saw the deceased alive on 8-2-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Timothy D. Carnes MD | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) TIMOTHY D. CARNES MD | |
| 23D. ADDRESS GOOD SAMARITAN HOSP. BAL, MD. | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | |
| 24B. DATE Aug 5, 1972 | | 24C. NAME of CEMETERY or CREMATORY Ft Lincoln Cemetery | | 24D. LOCATION (City, town, or county) (State) Colmar Manor Pro Geo Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 7 1972 | | 25B. NAME OF REGISTRAR Edith H. Hooton | | 25C. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07436

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

72 07436

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Mr Fred Allen Cranford

2. DATE AND HOUR OF DEATH

8 4 72 12 12 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Bon Secours Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

410 S Payson MD.

C. CITY OR TOWN

BALTO MD

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

410 S. Payson St. 21223

5. SEX

MALE

6. RACE

W

7. MARRIED

☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

3-4-14

9. AGE (In years last birthday)

58

11. Under 1 Yr.

Months Days

12. Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Stewart Monquire Salem VA

11. BIRTHPLACE (State or foreign country)

N C

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

unknown Mary Pentress

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

-

17. INFORMANT

Sarah Cranford 410 S. Payson St.

ADDRESS

18.

492X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Obstructive bronchopulmonary disease

10 days.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Severe Pulmonary emphysema

(C)

-

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

-

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

-

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

-

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

-

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

-

21C. WHERE DID INJURY OCCUR?

-

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

-

(Month) (Day) (Year) (Hour)

-

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

-

22. I certify that (I) (this hospital) attended the deceased from 7/25/72 19 to 8/4/72 19 that (I) (we) last saw the deceased alive on 8/4/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Chaihan

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

DEGREE

23B. DATE SIGNED

8/4/72

23C. PHYSICIAN'S NAME (Type)

CHAIHAN

23D. ADDRESS

Bon Secours Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/7/72

24C. NAME of CEMETERY or CREMATORY

Meadowridge Cem.

24D. LOCATION

24D. LOCATION (City, town, or county) (State)

24D. LOCATION (City, town, or county) (State)

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 7 1972

25B. NAME OF REGISTRAR

John J. Brown

25C. FUNERAL DIRECTOR

John J. Brown

25C. FUNERAL DIRECTOR ADDRESS

25C. FUNERAL DIRECTOR ADDRESS

The Board of Directors of the Company has the honor to acknowledge the receipt of the report of the Management for the year ending December 31, 1911. The report is a most interesting and valuable one, and it is a pleasure to find that the Management has been able to accomplish so much during the year. The Board is confident that the Company will continue to prosper and that the Management will continue to do a most efficient and successful work.

RESOLVED, That the Board of Directors of the Company do hereby approve the report of the Management for the year ending December 31, 1911, and do hereby authorize the President of the Company to sign the same.

Attest:
Secretary

Chairman

Director

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07437

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

72 07437

STATE OF MARYLAND-DEATH

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

LANTZ, WESLEY LLOYD

2. DATE AND HOUR OF DEATH

AUGUST 2, 1972

10:05A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

ST AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, If institution residence before admission)

A. STATE

B. COUNTY

MARYLAND

BALTIMORE

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

1012 Rowe LA

21207

5. SEX

MALE

6. RACE

CAUCASIAN

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

03 08 25

9. AGE (In years
last birthday)

47

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

COMPTOMETER OPERATOR

10B. KIND OF BUSINESS OR INDUSTRY

RAILROAD

11. BIRTHPLACE (State or foreign country)

OHIO

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

RALPH LANTZ

14. MOTHER'S MAIDEN NAME

MATHILDA BRAUER

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

YES

WW 2

16. SOCIAL
SECURITY NO.

274 20 6427

17. INFORMANT

ST AGNES HOSPITAL RECORDS CATON AND
WILKENS AVES BALTO MD 21229

ADDRESS

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

4 days

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ☒ (this hospital) attended the deceased from JULY 28, 1972 to AUGUST 2, 1972,
that ☒ (we) last saw the deceased alive on AUGUST 2, 1972 and that in ☒ (our) opinion death occurred on the date
and hour and from the causes stated above. ☒ (we) (did) ☒ view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S
NAME (Type)

JOSE APTER MD

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

08/02/72

23D. ADDRESS

ST AGNES HOSPITAL BALTO MD 21229

24A. BURIAL CREMATION,
REMOVAL (Specify)

CREMATION

24B. DATE

8-5-72

24C. NAME OF CEMETERY OR CREMATORY

LONDON PARK CEM.

24D. LOCATION

(City, town, or county)

BALTO, MD

25A. DATE REC'D BY HEALTH DEPT.

AUG 7 1972

25B. NAME OF REGISTRAR

Dorothy W. Houston

25C. FUNERAL DIRECTOR

FRANSPERRY J.T.

ADDRESS

4411 Windsoy Mill

10-000

AUGUST 2, 1952

LAURENCE, JULY 1952

ST. AGNES HOSPITAL

ST. AGNES HOSPITAL

ST. AGNES HOSPITAL

09 08 52

09 08 52

09 08 52

U.S.A.

U.S.A.

U.S.A.

U.S.A.

MATHIAS, JULY 1952

MATHIAS, JULY 1952

ST. AGNES HOSPITAL RECORDS SECTION
234 20 6457 WILKES AVE. BALTO MD 21229

ST. AGNES HOSPITAL RECORDS SECTION
234 20 6457 WILKES AVE. BALTO MD 21229

ST. AGNES HOSPITAL RECORDS SECTION
234 20 6457 WILKES AVE. BALTO MD 21229

ST. AGNES HOSPITAL RECORDS SECTION
234 20 6457 WILKES AVE. BALTO MD 21229

YES

AUGUST 2, 1952

YES

JULY 1952

AUGUST 2, 1952

XXXXXX

09 08 52

YES

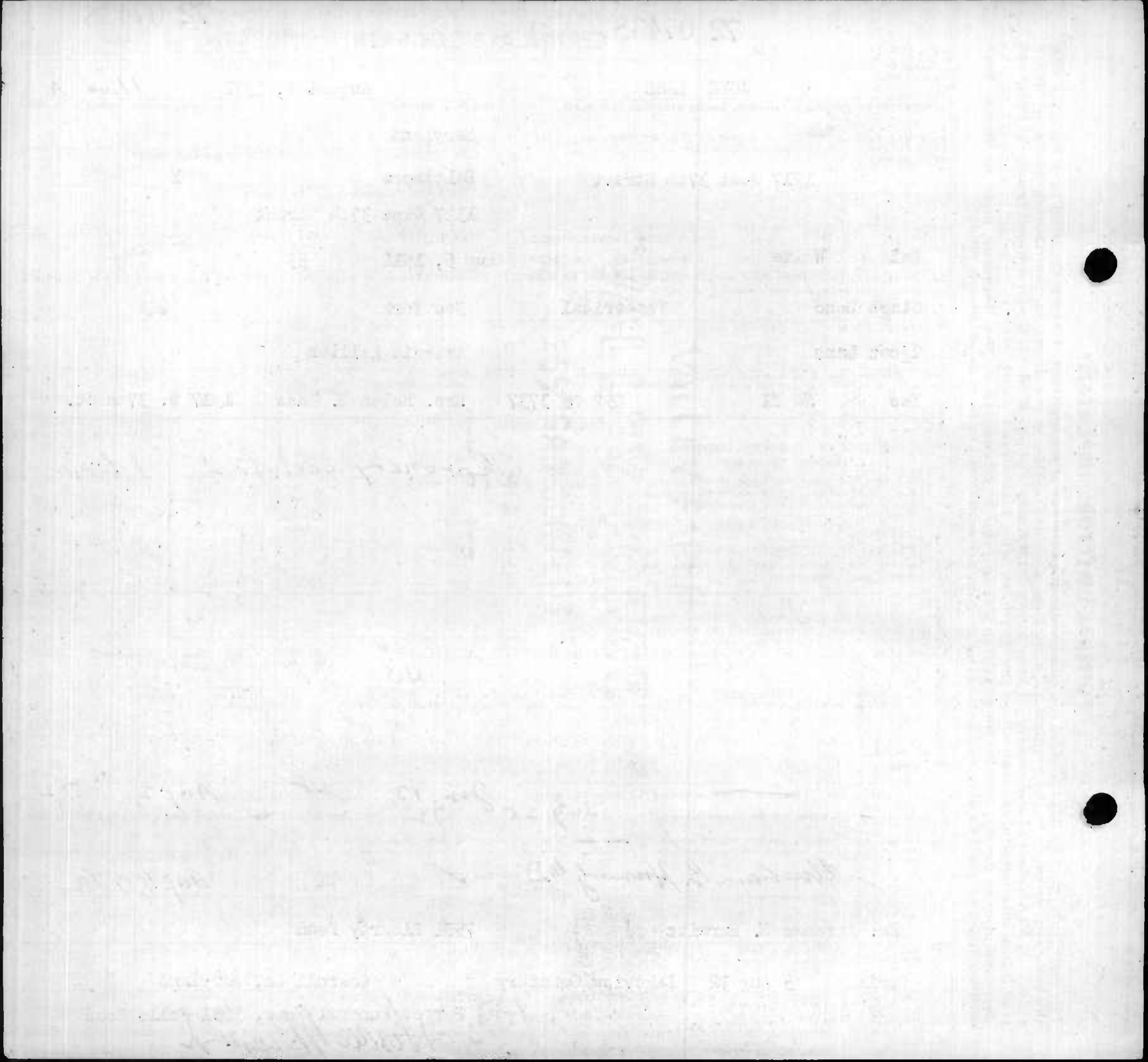
ST. AGNES HOSPITAL BALTO MD 21229

JOSE PETER MD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07438 | | 72 07438 | |
|--|--|--|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | STATE OF MARYLAND-DHMH | |
| BIRTH NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | August 2, 1972 11:00 A. M. | | | |
| JOHN LASS | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | | | |
| 1317 West 37th Street | | | | Maryland | | | |
| | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER | | | |
| | | | | 1317 West 37th Street | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| Male | | White | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Aug 5, 1912 | |
| | | | | | | 59 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday) | |
| Stage Hand | | | | Theatrical | | 59 | |
| 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| New York | | | | USA | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Ignaz Lass | | | | Antonia Kalliah | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| Yes WW II | | | | 092 05 3737 | | Mrs. Helen B. Lass 1317 W. 37th St. | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| I | | | | 1 hour | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) IMMEDIATE CAUSE | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | Coronary occlusion | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | NO | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | White At <input type="checkbox"/> Work Not White At <input type="checkbox"/> Work | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 13, 1968 to Aug. 2, 1972, that (I) (we) last saw the deceased alive on July 25, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Abraham B. Hurwitz MD | | | | Aug. 4, 1972 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Dr. Abraham B. Hurwitz | | | | 7501 Liberty Road | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 5 Aug 72 | | Lakeview Cemetery | | Carroll Co, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| AUG 7 1972 | | Edney H. Boston | | Burgee Funeral Home, 3631 Falls Road | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

REG. NO. 72 07439
STATE OF MARYLAND-DEPT

YS 150-REV. 1/1/68

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

m-6241

72 07440

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

72 07440

STATE OF MARYLAND-DEMD

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

FRANK MARSELLA

2. DATE AND HOUR OF DEATH

8-3-72

6:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

The Good Samaritan Hosp.

4-5

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE & COUNTY

Baltimore, Md.

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

3705 Keswick Rd.

5. SEX

MALE

6. RACE

White

7. MARRIED

☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

7-15-25

9. AGE (In years last birthday)

47

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Letter Carrier

10B. KIND OF BUSINESS OR INDUSTRY

U.S. Post Office

11. BIRTHPLACE (State or foreign country)

Rhode Island

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Antonio Marsella

14. MOTHER'S MAIDEN NAME

Aldina Gazcellone

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL SECURITY NO.

037 14 2242

17. INFORMANT

ADDRESS

Mrs. Marian Marsella 3705 Keswick Road

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.

Carcinoma of lung with metastases

11 months

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/1/72 to 8/3/72 that (I) (we) last saw the deceased alive on 8/3/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S NAME (Type)

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

8/3/72

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7 Aug 72

24C. NAME OF CEMETERY or CREMATORY

Dulaney Valley Cemetery

24D. LOCATION

(City, town, or county)

(State)

Cockeysville, Bal to Co Md

25A. DATE REC'D BY HEALTH DEPT.

AUG 7 1972

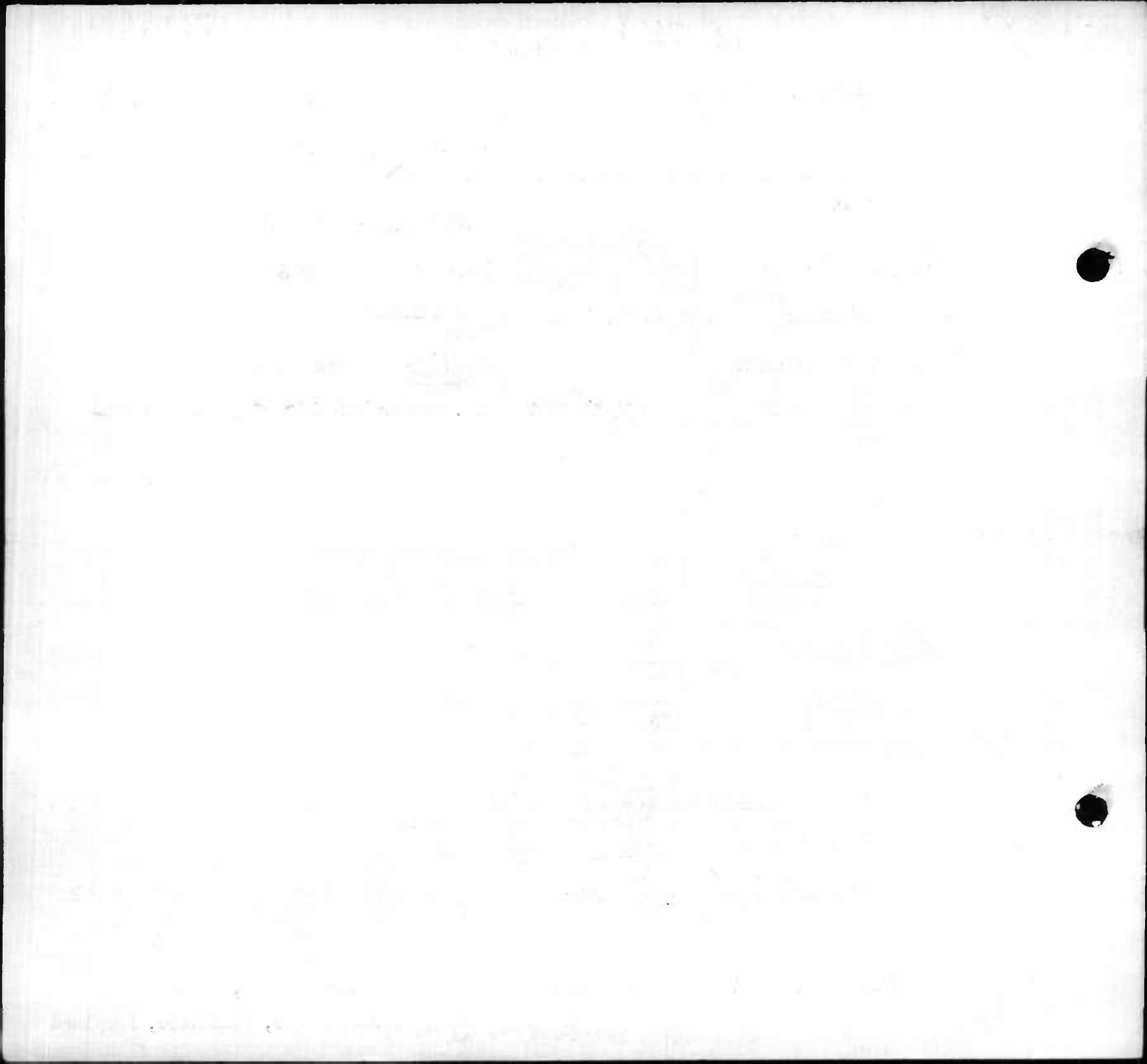
25B. NAME OF REGISTRAR

John A. Houston

25C. FUNERAL DIRECTOR

Burges Funeral Home, Baltimore, Maryland

ADDRESS



72 07441

BALTIMORE CITY HEALTH DEPARTMENT

72 07441

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND-DEMH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

PATRICK FRANCIS O'NEILL

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

44 UNION MEMORIAL HOSPITAL

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

August 1, 1972

11:20 P.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

1206

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

March 17 1904

10. AGE (In years
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

112 W. 27th Street

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Patrick O'Neill

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Salesman

14B. KIND OF BUSINESS OR INDUSTRY

Liquors

15. MOTHER'S MAIDEN NAME

Ellen Moore

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

213 01 1343

18. INFORMANT

ADDRESS

Leona H. O'Neill 112 W. 27th Street

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Carcinoma of Jaw

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐Deputy CHIEF MEDICAL EXAMINER ☒ACTUAL
SIGNATURE

EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/2/72

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

5 Aug 72

24C. NAME of CEMETERY or CREMATORY

New Cathedral Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 7 1972

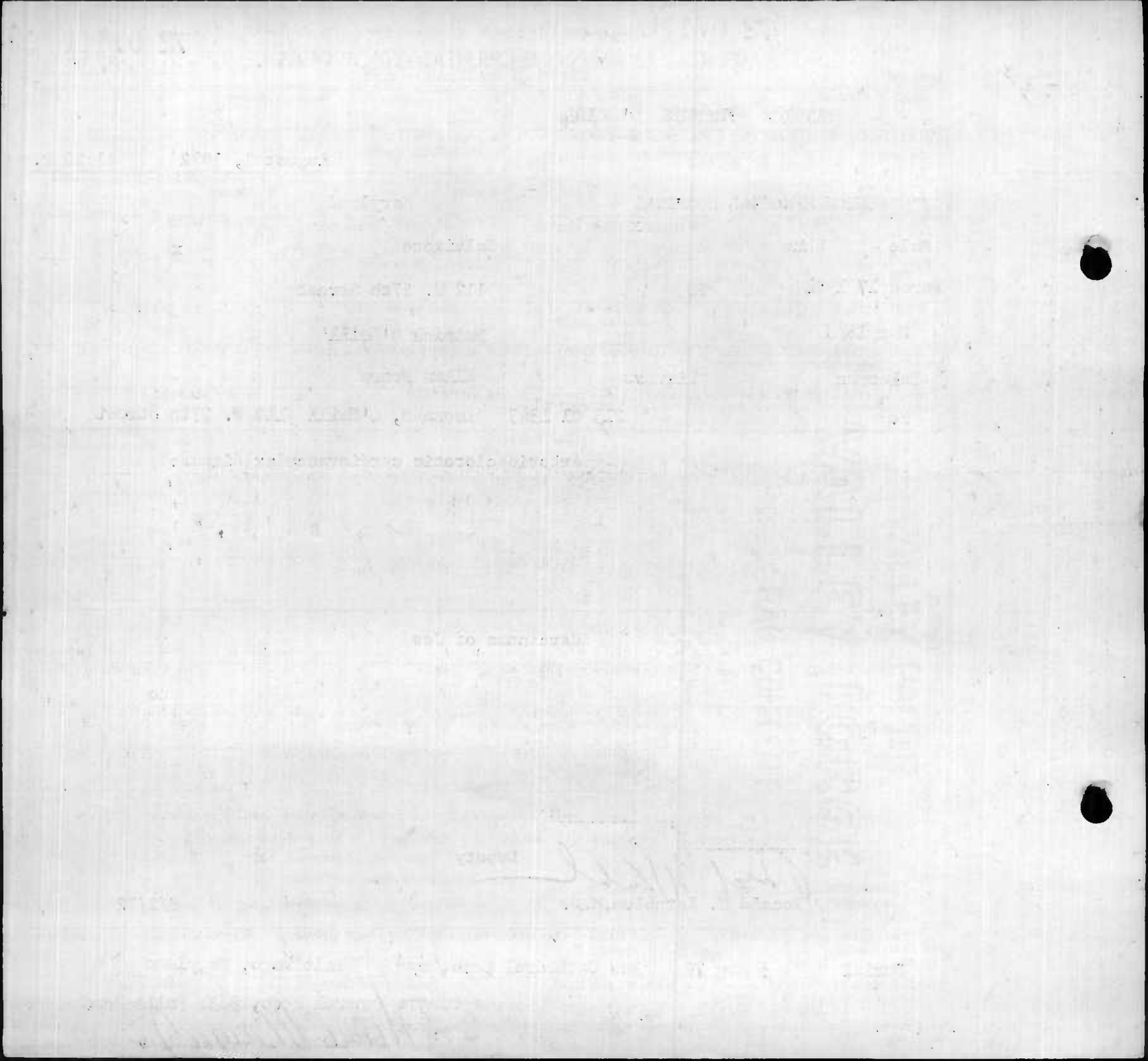
25B. NAME OF REGISTRAR

Sandra H. Whorton

25C. FUNERAL DIRECTOR

Burgee Funeral Home, 3631 Falls Road

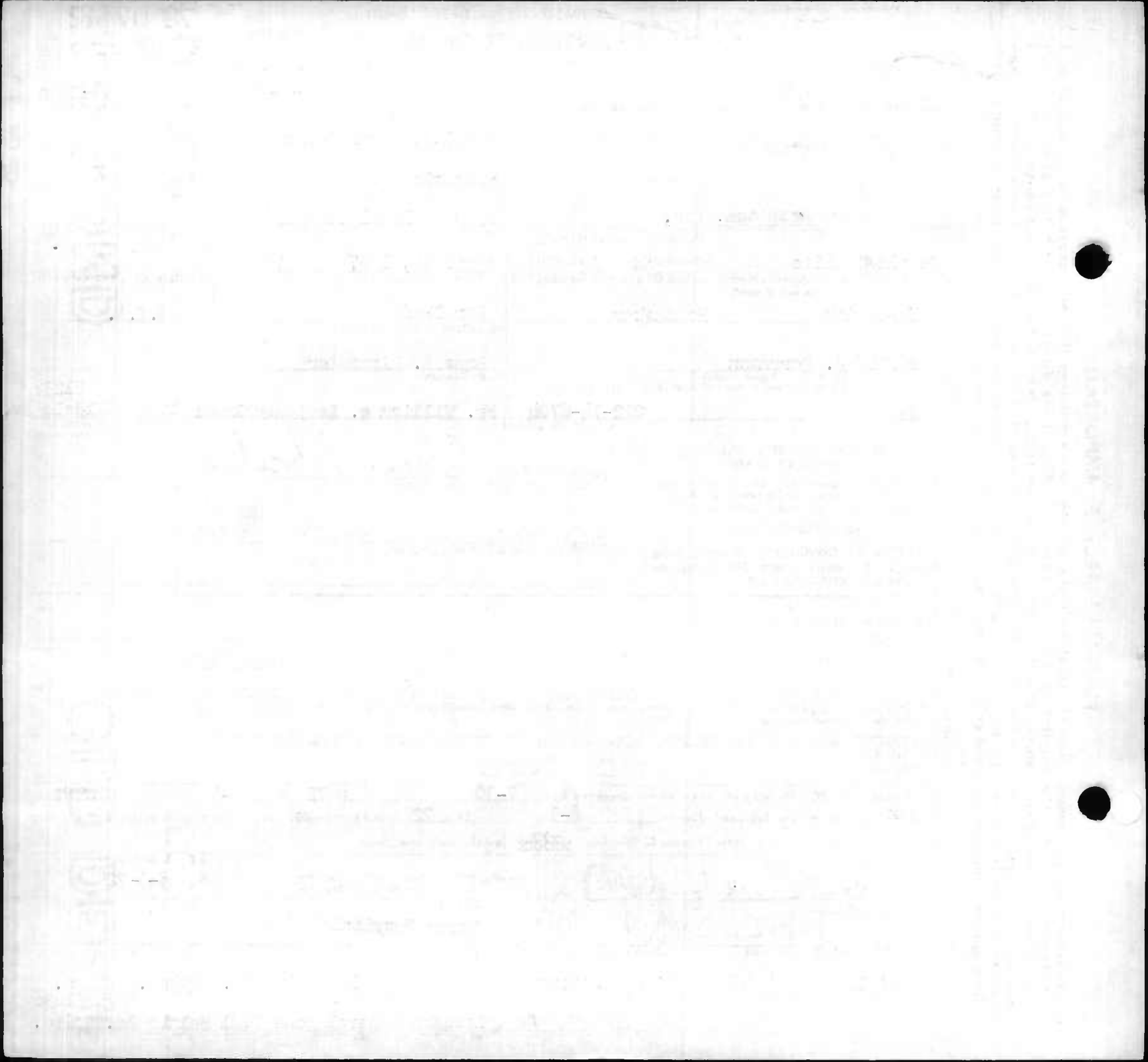
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07442 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07442 | |
|---|--|--|--|--|--|---|--|--|--|
| 72 07442 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | BALTIMORE CITY HEALTH DEPARTMENT | | BALTIMORE CITY HEALTH DEPARTMENT | |
| 72 07442 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | BALTIMORE CITY HEALTH DEPARTMENT | | BALTIMORE CITY HEALTH DEPARTMENT | |
| BIRTH NO. | | | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | STATE OF MARYLAND-DHMH | |
| | | | | Adela Ackerman | | 8-3-72 11:20 A. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | | | |
| 37 Mercy Hospital, Inc. | | | | | | Maryland Baltimore | | 5300 | |
| 5. SEX | | | | 6. RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| Female | | | | White | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | April 27, 1897 75 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Housewife | | | | Homemaker | | Maryland | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| Edward J. Herrmann | | | | Emma A. Niamaster | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | | | 212-74-8704 | | Mr. William e. Lautenschlager | | 21237 1242 Hilldale Av. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | Coronary Thrombosis | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | Arteriosclerotic Cardiovascular Disease | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (X) (this hospital) attended the deceased from 7-30 19 72 to 8-3 19 72 that (X) (we) last saw the deceased alive on 8-3 19 72 and that in (240) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (view) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | | | |
| John E. Serbel, MD | | | | 8-3-72 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| John E. Serbel, MD | | | | Mercy Hospital | | | | | |
| 24A. BURIAL-CREATION, REMOVAL (Specify) | | | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | | | 8/7/72 | | Zion Cemetery | | Golden Ring Rd. Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| AUG 7 1972 | | | | Sidney Johnston | | Lassahn Funeral Home | | 21236 7401 Belair Rd. Balto. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>72 07443</u> |
|--|-------------------------|---|------------------------------------|--|
| CERTIFICATE OF DEATH | | | | STATE OF MARYLAND-DHMH |
| BIRTH NO. <u>72-12213</u> | | 1. NAME OF DECEASED (Type or Print) <u>Baby Boy Cook</u> | | 2. DATE AND HOUR OF DEATH <u>7-29-72</u> <u>6:45</u> <u>A.M.</u> |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>37 MERCY HOSPITAL</u> | | A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <u>X</u> |
| | | E. STREET AND NUMBER <u>923 S. Linwood, Ave.</u> <u>(over) 2636</u> | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-25-72</u> | 9. AGE (In years last birthday) <u>4</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> |
| 13. FATHER'S NAME <u>Paul B. McDonald</u> | | 14. MOTHER'S MAIDEN NAME <u>Linda A. Cook</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT <u>Paul B. McDonald</u> ADDRESS <u>923 S. Linwood, Ave.</u> |
| 18. <u>722.01</u> CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Sub Arachnoid Hemorrhage.</u> | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u> |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that <u>(1)</u> (this hospital) attended the deceased from <u>7-25</u> 19 <u>72</u> to <u>7-29</u> 19 <u>72</u> that <u>(1)</u> (we) last saw the deceased alive on <u>7-29</u> 19 <u>72</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(1)</u> (We) (did) <u>(not)</u> view the body after death. | | | | |
| 23A. SIGNATURE <u>Immanuel N. Macorade</u> | | | | 23B. DATE SIGNED <u>7/31/72</u> |
| 23C. PHYSICIAN'S NAME (Type) <u>IMMANUEL N. MACORADE</u> | | 23D. ADDRESS <u>MERCY HOSPITAL</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>8-4-72</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Restmont Cemetery</u> |
| 24D. LOCATION <u>Cumberland Md. Garrett Co.</u> | | 24E. (City, town, or county) (State) <u>Balto. Md.</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 7 1972</u> | | 25B. NAME OF REGISTRAR <u>Sidney W. Hudson</u> | | 25C. FUNERAL DIRECTOR <u>John J. Duda Inc. Hudson, St. & Linwood, Ave.</u> |

Hospital Called - address 6212 Copore Way H.B.

C-145-1
61-55-68 djr

72 07444

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 07444

STATE OF MARYLAND-DMH

BIRTH NO.

1. NAME OF DECEASED Allen B. Copeland, Sr.

(Type or Print)

ALLEN COPELAND

2. DATE AND HOUR OF DEATH

1 August 1972 13:25 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland Baltimore

C. CITY OR TOWN

Edgemere

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

7102 Ella Avenue 21219

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

9-20-93

9. AGE (In years last birthday)

78

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Welder

10B. KIND OF BUSINESS OR INDUSTRY

Beth. Steel Co.

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Copeland

14. MOTHER'S MAIDEN NAME

Daisy

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

213-09-3465A

17. INFORMANT

BCH: RECORDS

4940 Eastern Avenue

Baltimore, Maryland 21224

18.

43001

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CARDIO-PULMONARY ARREST

5 days

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Sub Arachnoid Hemorrhage (CVA)

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

PROBABLE HYPERTENSION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 25 July 1972 to 1 August 1972, that (I) (we) last saw the deceased alive on 1 August 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Peter B. DeOreo, M.D.

DEGREE

Attending Phys. ☒Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

1 August 1972

23C. PHYSICIAN'S NAME (Type)

Peter B. DeOreo M.D.

DEGREE

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Avenue Baltimore, Maryland

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-4-72

24C. NAME OF CEMETERY or CREMATORY

Moreland Memorial Park

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 7 1972

25B. NAME OF REGISTRAR

Audrey Johnston

25C. FUNERAL DIRECTOR

John J. Duda 7922 Wise Ave. Dundalk, Md.

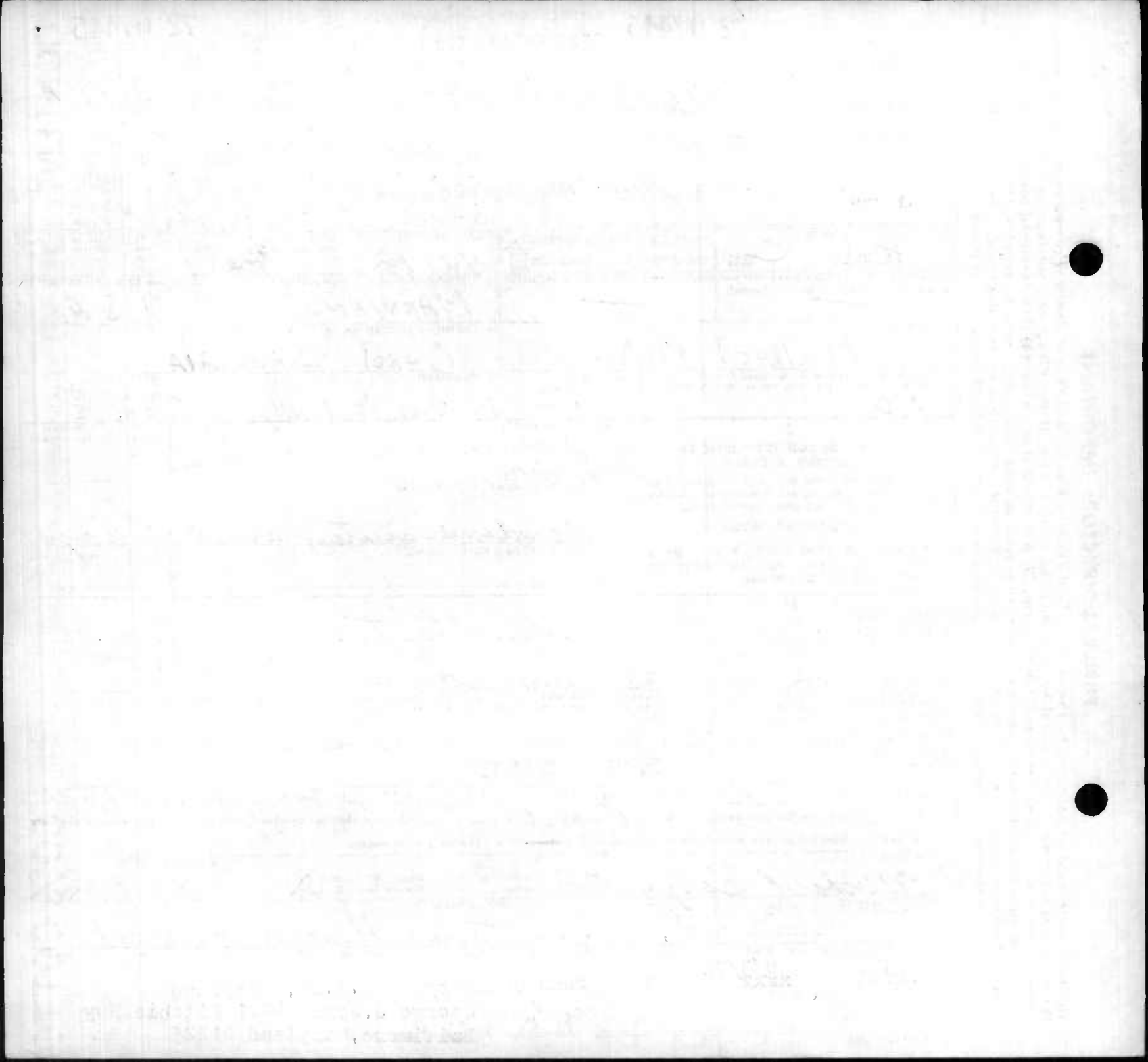
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|--------------------|--|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07445 ✓ | |
| M-254 72 07445 | | STATE OF MARYLAND-DEM | |
| BIRTH NO. 72-03545 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) McNally, Michele Lee | | 2. DATE AND HOUR OF DEATH 8/11/72 12:29 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Baltimore 2544 | |
| FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | E. STREET AND NUMBER 3806 St. Victor St. #25 | |
| 5. SEX Female | 6. RACE Cau | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/11/72 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 42 |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Michael McNally | | 14. MOTHER'S MAIDEN NAME CAROL IADEVANA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Michael McNally | | ADDRESS Same AS ABOVE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) progressive anoxic brain damage | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiorespiratory arrest 4 days | |
| (B) _____ | | (C) _____ | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). neuroblastoma | | 4 mos. | |
| 19A. DATE OF OPERATION 7/25/72 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED metastatic neuroblastoma | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 24, 1972 to August 4, 1972 that (I) (we) last saw the deceased alive on August 19, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Michael Borzy, M.D. | | 23B. DATE SIGNED 8/11/72 | |
| 23C. PHYSICIAN'S NAME (Type) Michael Borzy, M.D. | | 23D. ADDRESS Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/3/72 | |
| 24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery | | 24D. LOCATION (City, town, or county) (State) A.A.Co, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 7 1972 | | 25B. NAME OF REGISTRAR George J. Gonce | |
| 25C. FUNERAL DIRECTOR ADDRESS 4001 Ritchie Hwy | | 25D. ADDRESS Baltimore, Maryland 21225 | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07446

REG. NO.

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) SADIE MC CRAE | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 29 1972 12:15p M. | |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1501 | | C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 6. SEX female | 7. RACE negro | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH MAY 16, 1931 | 10. AGE (In years lost birthday) 41 | 11. BIRTHPLACE (State or foreign country) ALABAMA | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME J. Baker | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 15. MOTHER'S MAIDEN NAME Emeline Stoke (Stone) | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT Ice Mae Taylor ADDRESS 102-54 188th St. Hollis, N.Y. | |
| 19. CAUSE OF DEATH Gunshot wound of head | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1525 Pressman St. | | | |
| 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 7-29-72 8:53a | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? Shot by husband. | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Marvin S. Platt M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) transit-Burial | | 24B. DATE AUG-4, 1972 | |
| 24C. NAME OF CEMETERY or CREMATORY mt. Calvary Baptist Church | | 24D. LOCATION (City, town, or county) (State) Alexander City Alabama. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 7 1972 | | 25B. NAME OF REGISTRAR Sidney W. Houston | |
| 25C. FUNERAL DIRECTOR Marshall W. Jones Jr. | | ADDRESS 135 Hayford Ave. | |

75 0710

CHIEF

MAY 16, 1931

RECEIVED

J. Davis
Cable Station (2nd)

For one copy 1931 of 1931

Great Hall 4th Flr. in City of London
Museum of London

M-200

72 07447 BALTIMORE CITY HEALTH DEPARTMENT

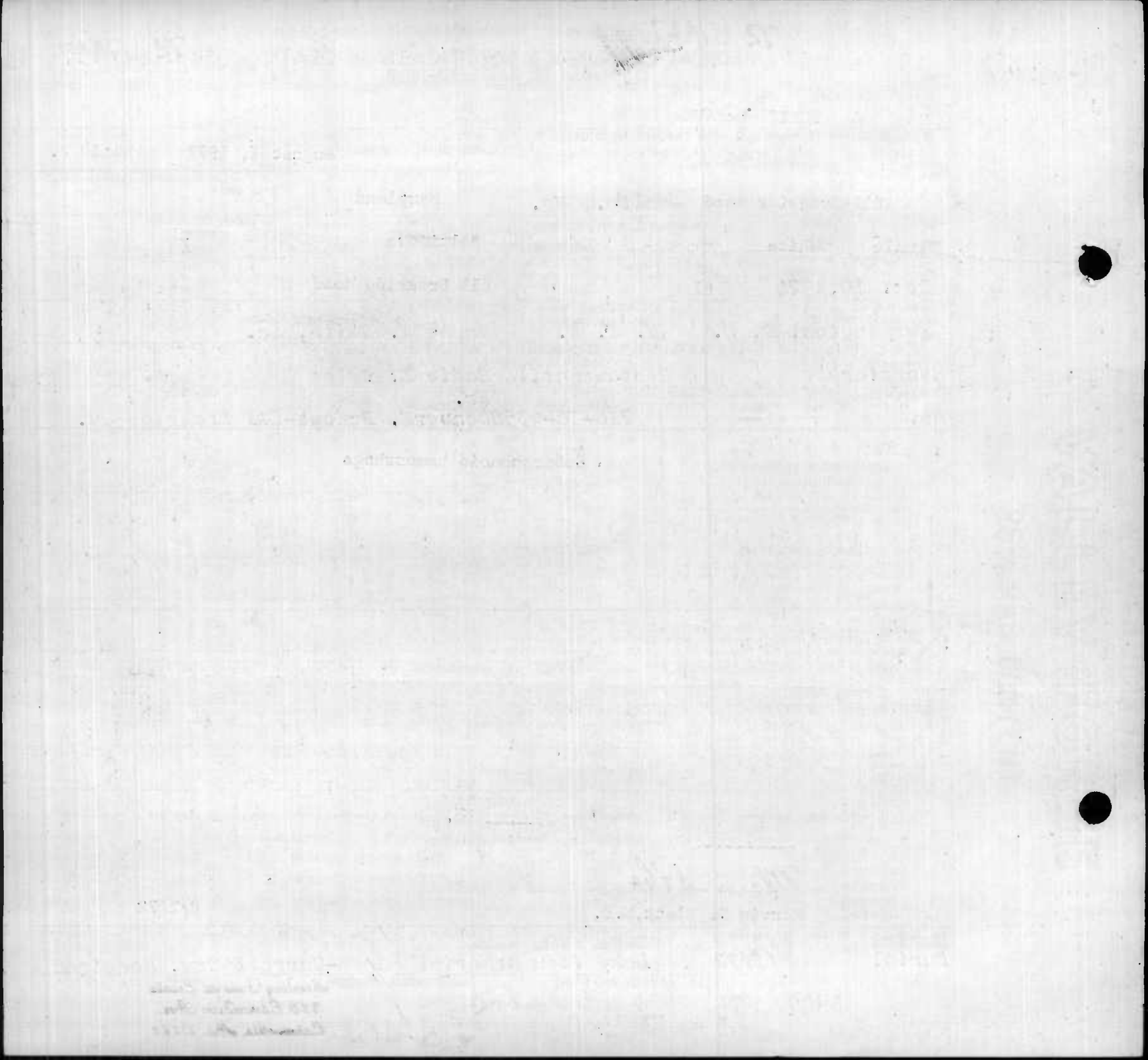
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07447

BIRTH NO.

REG. NO.

| | | | | | | | |
|---|-------------------------|---|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) DORIS V. McKAYE | | | | 2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour M. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 611 Braeside Road - Balto., Md. | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour August 1, 1972 4:10 P. M. | | | |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2854 | | | | | | | |
| 6. SEX Female | 7. RACE White | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH Dec. 19, 1924 | | 10. AGE (In years last birthday) 47 | | E. STREET AND NUMBER 611 Braeside Road | | | |
| 11. BIRTHPLACE (State or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME Wayne A. Smith, Sr. | | | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary | | 14B. KIND OF BUSINESS OR INDUSTRY M M Restaurant, Inc | | 15. MOTHER'S MAIDEN NAME Sadie E. Lyles | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. 218-18-4358 | | 18. INFORMANT E. McKaye-611 Braeside Rd. | | | |
| 19. 430.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Subarachnoid hemorrhage CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 21. AUTOPSY? (Yes or No) yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. DATE SIGNED 8/2/72 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/3/72 | | 24C. NAME of CEMETERY or CREMATORY Lake View Memorial Park - Carroll Cty, Maryland | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 7 1972 | | 25B. NAME OF REGISTRAR James Anderson | | 25C. FUNERAL DIRECTOR Sterling Funeral Home 736 Edmondson Ave. Catonsville, Md. 21228 | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07448

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

72 07448

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARIE. C. SCHWERT

2. DATE AND HOUR OF DEATH

8-01-72

9 10

A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BON SECOURS

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE

MD.

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

301 MC MECHEN ST.

5. SEX

F

6. RACE

CAUCASIAN

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

5/26/1895

9. AGE (In years
last birthday)

77

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Clerk

10B. KIND OF BUSINESS OR INDUSTRY

City of Balto

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Carl W. Schulz

14. MOTHER'S MAIDEN NAME

Helena Pilgrim

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

214 40 4164

17. INFORMANT

ADDRESS

Mrs. Mildred Koenig 502 Wilton Rd.

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

ASCVD - MULTIPLE ARRHYTHMIAS

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

POSSIBLE CEREBRAL EMBOLISM

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

DAYS

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

CEREBRAL ARTERIOSCLEROSIS

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7-17-72 to 8-01-72
that (I) (we) lost saw the deceased alive on 7-31-72 and that (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Oscar E. Ferdinandini M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

8-01-72

23C. PHYSICIAN'S
NAME (Type)

OSCAR E. FERNANDINI M.D.

23D. ADDRESS

BON SECOURS HOSP.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/3/72

24C. NAME OF CEMETERY or CREMATORY

Gardens of Faith

24D. LOCATION

(City, town, or county)

Baltimore

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 7 1972

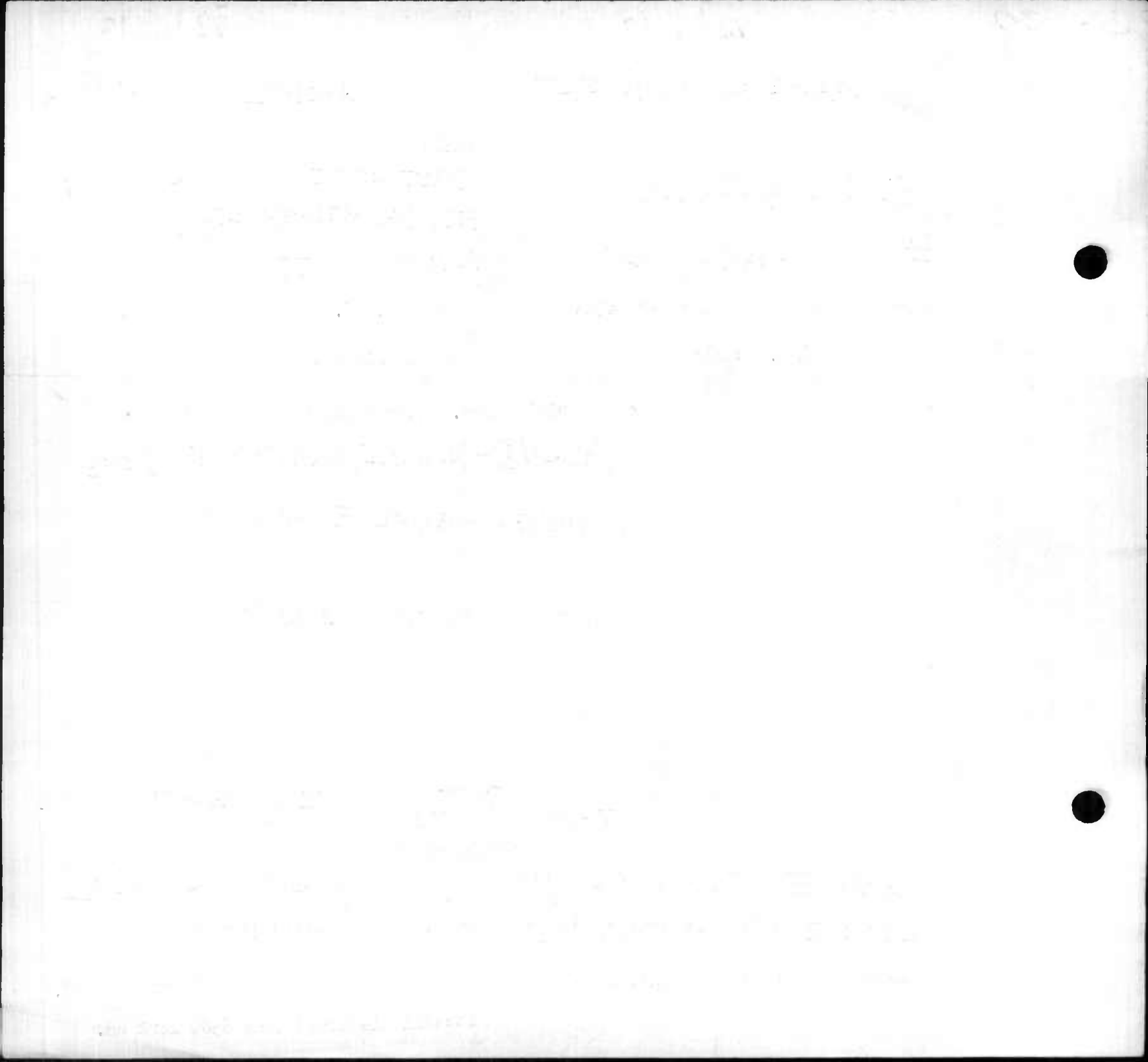
25B. NAME OF REGISTRAR

J. J. J. J. J.

25C. FUNERAL DIRECTOR

Mitchell Wiedefeld Home 6500 York Rd.

ADDRESS



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07449

BIRTH NO.

STATE OF MARYLAND-DEPT

REG. NO.

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) EDWARD A. HEALY EDWARD HEALY | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL | | 3. DATE PRONOUNCED DEAD Month Day Year Hour July 31, 1972 6:27 P.M. | |
| 6. SEX Male | | 7. RACE White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | |
| D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER 5514 Midwood Avenue | |
| 9. DATE OF BIRTH 2/19/1926 | | 10. AGE (In years lost birthday) 46 46 | |
| 11. BIRTHPLACE (State or foreign country) BALTIMORE, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME EDW. P. HEALY | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENG. STATE ROADS | |
| 15. MOTHER'S MAIDEN NAME MILDRED LIDIE | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) YES WW 2 | |
| 17. SOCIAL SECURITY NO. 219-18-0231 | | 18. INFORMANT ADDRESS Mr. JOHN P. HEALY- (Bro.) | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 4124 I | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 20A. DATE OF OPERATION 8/4/72 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: Ronald N. Kornblum, M.D. DATE SIGNED: 8/1/72 EXAMINER'S NAME (Type) | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 8/4/72 | |
| 24C. NAME OF CEMETERY or CREMATORY DULANY VALLEY MEM. | | 24D. LOCATION (City, town, or county) (State) BALTO. Co. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | |
| 25C. FUNERAL DIRECTOR MITCHELL-WIEDEFELD HOME | | ADDRESS 6500 York Rd. 21212 | |

12-1-1941
J. Edgar Hoover
Director
Federal Bureau of Investigation
Washington, D. C.

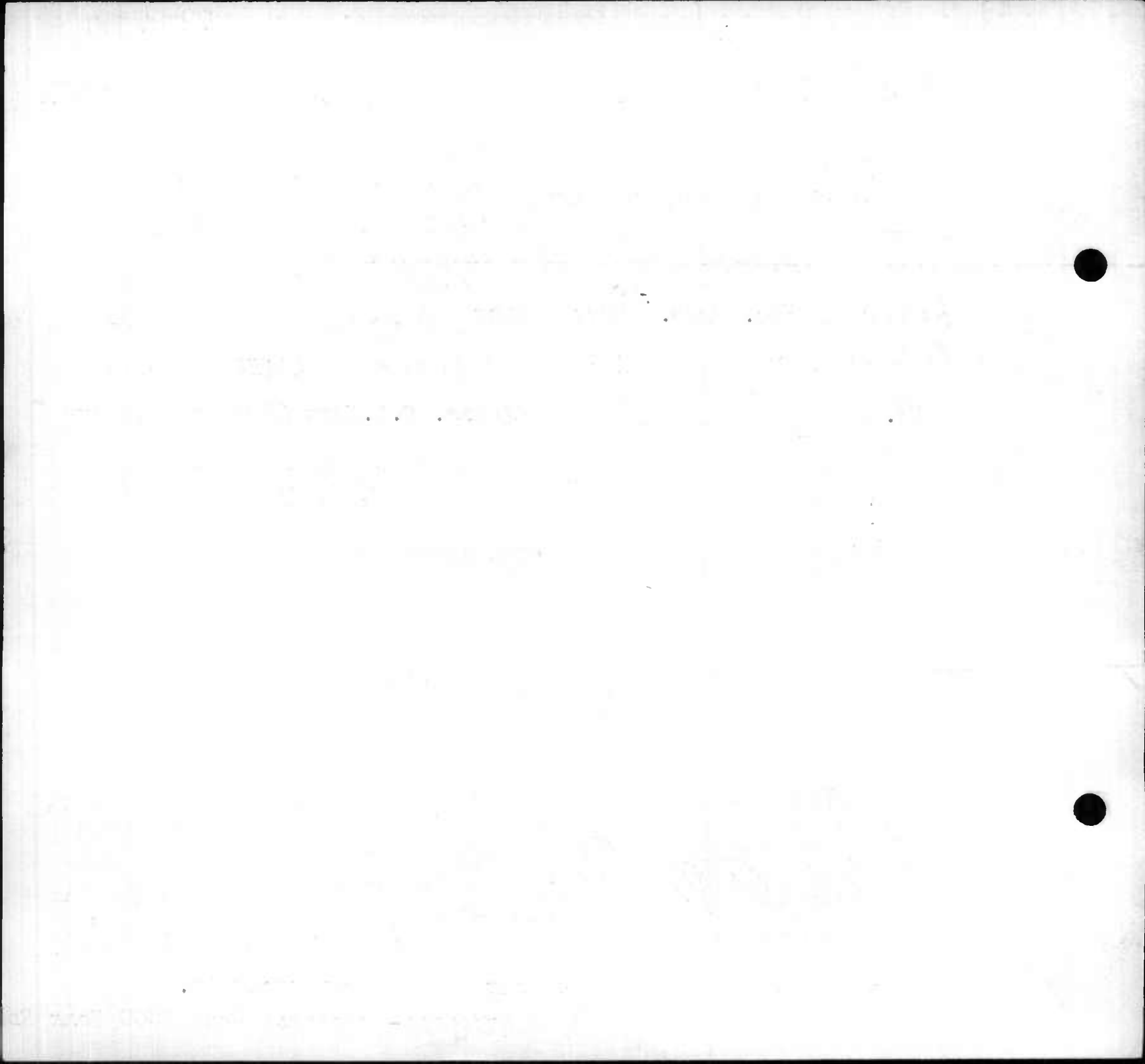
TO: SAC, NEW YORK
FROM: SAC, BOSTON
SUBJECT: [Illegible]
RE: [Illegible]

[Illegible body text]

[Illegible body text]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|-----------------------------|--|-------------------------------------|--|--|---|--|
| N-2001 | | 72 07450 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07450 | |
| CERTIFICATE OF DEATH | | | | REG. NO. _____ | | | |
| 1. NAME OF DECEASED (Type in Print) CHARLES G. NACE | | | | 2. DATE AND HOUR OF DEATH 7-29-72 705 PM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY _____ | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BON SECOURS HOSP. 342025 W. FAYETTE ST. | | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 1205 Evesham Ave | | | |
| 5. SEX M | 6. RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/29/07 | 9. AGE (in years last birthday) 64 | If Under 1 Yr. Months: _____ Days: _____ | | If Under 24 Hrs. Hours: _____ Min. _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED ENG. INSP. WESTINGHOUSE | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY USA | | | | 13. FATHER'S NAME CHARLES HANSON NACE | | | |
| 14. MOTHER'S MAIDEN NAME MARTHA E. NACE Geidt | | | | 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No. | | | |
| 16. SOCIAL SECURITY NO. 212-63-3920 | | | | 17. INFORMANT ADDRESS MRS. C.G. NACE 1205 EVESHAM AVE | | | |
| 18. CAUSE OF DEATH 412.41 | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Ante mortem death | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ACCD | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) | | | | | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 7/22 19 72 to 7/29 19 72 and that (2) (we) last saw the deceased alive on 7/29 19 72 and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE FELIX A. SORIE MD | | | | 23B. DATE SIGNED 7-28-72 | | 23C. PHYSICIAN'S NAME (Type) FELIX A. SORIE MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 8/2/72 | | 24C. NAME OF CEMETERY or CREMATORY LOUDON PARK | | 24D. LOCATION (City, town, or county) (State) BALTIMORE MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 7 1972 | | 25B. NAME OF REGISTRAR Gregory H. Heston | | 25C. FUNERAL DIRECTOR MITCHELL-WIEDEFELD HOME | | ADDRESS 6500 YORK RD | |



CERTIFICATE OF DEATH

STATE OF MARYLAND-DEHE

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ALDA ZEARES

2. DATE AND HOUR OF DEATH

2 Aug 1972 17 30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1 BALTIMORE CITY HOSPITALS
4940 Eastern Ave., Baltimore, Md. 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN
BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER 4940 Eastern Ave. 21224

Baltimore City Hospitals

5. SEX

Female

6. RACE

Caucasian

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

10 Nov 1885

9. AGE (in years
last birthday)

86

11. Under 1 Yr.
Months Days

11 Under 24 Hrs.
Hours Min.

10A. USUAL OCCUPATIONS (Give kind of work
done during most of working life, even if retired)

PRODUCE MERCHANT

10B. KIND OF BUSINESS OR INDUSTRY

SELF EMPLOYED

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

JOHN. - ZEARES

14. MOTHER'S MAIDEN NAME

THERESA HENNIGAN

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

217-32-9907A

17. INFORMANT

Records: BCH-4940 Eastern Ave. 21224

ADDRESS

18.

43791

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cerebral arteriosclerosis
(Died in sleep)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

yes

(B)

DUE TO, OR AS A CONSEQUENCE OF:

A S C V O - C H F compensated

yes

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At ☐ Not While
Work ☐ At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 24 Aug 1970 to 2 Aug 1972
that (I) (we) last saw the deceased alive on 1 Aug 72 19 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Edmund G. Beacham

DEGREE

Attending
Phys. ☐

Med.
Director ☒

Staff
Phys. ☐

23B. DATE SIGNED

2 Aug 72

23C. PHYSICIAN'S
NAME (Type)

Edmund G. Beacham

23D. ADDRESS

Ave. Baltimore City Hospitals, 4940 Eastern
21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

Aug 5 72

24C. NAME OF CEMETERY or CREMATORY

HOLY CROSS

24D. LOCATION

RITCHIE HWY - Md

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 7 1972

25B. NAME OF REGISTRAR

Johny Johnston

25C. FUNERAL DIRECTOR

Francis General Home 1216 S. Charles St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

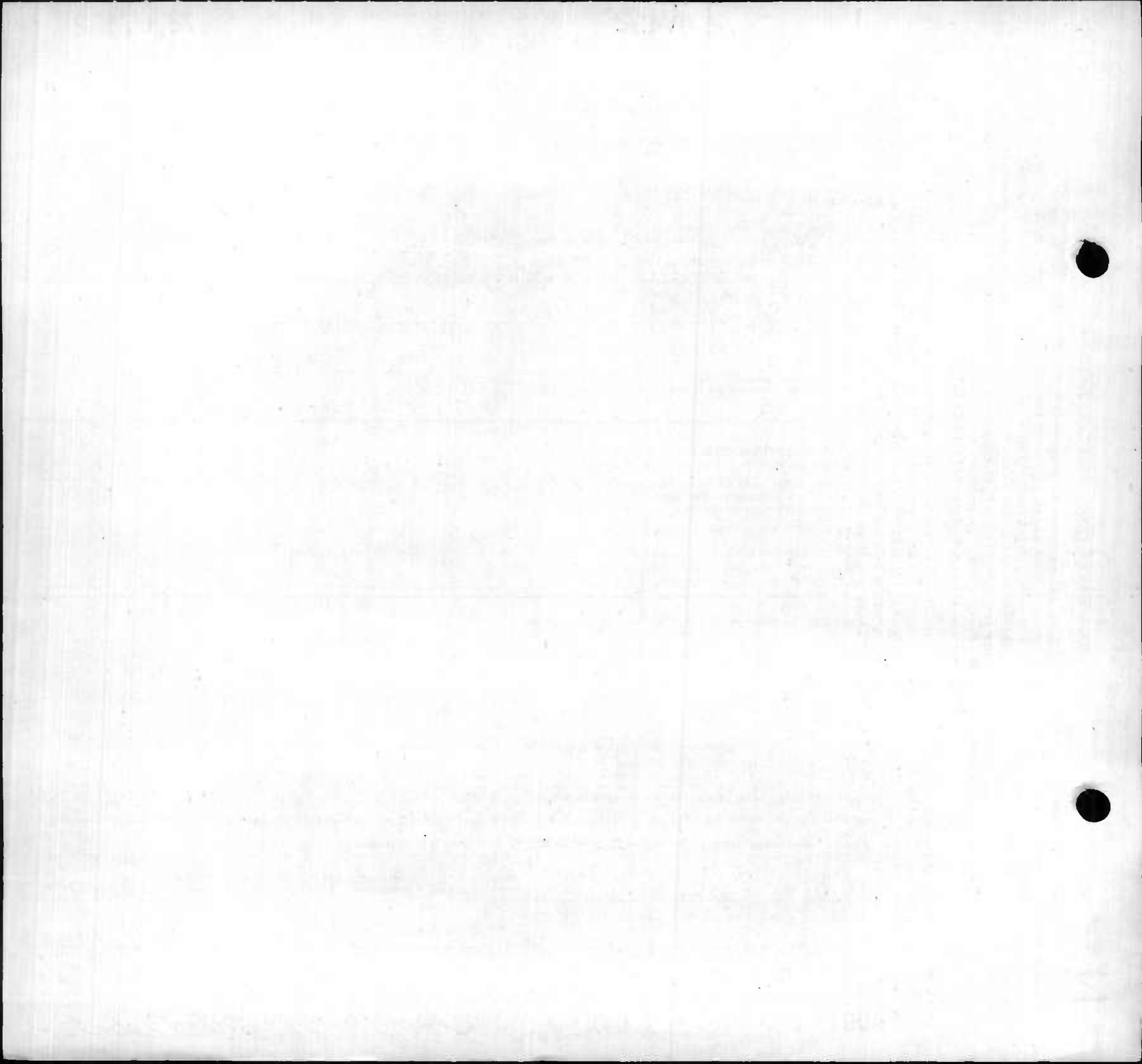
8/24/70

27 E. West St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 72 07452 BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07452 | |
|--|---------------------|---|-------------------------------------|---|---|
| CERTIFICATE OF DEATH | | | | REG. NO. 72 07452 | |
| STATE OF MARYLAND-DEM | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>JAMES SAMUEL DOWNEY</u> | | 2. DATE AND HOUR OF DEATH <u>JULY 28</u> <u>9¹⁵ A.M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2002</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY OF MD. HOSPITAL</u> | | C. CITY OR TOWN <u>BALTIMORE</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <u>48 N. GORMAN AVE. 21223</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>N</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10/02/00</u> | 9. AGE (In years last birthday) <u>71</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TANK OPERATOR NOW UNEMPLOYED</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 13. FATHER'S NAME <u>SAMUEL DOWNEY</u> | | 14. MOTHER'S MAIDEN NAME <u>MARY BURKE</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>?</u> | | 16. SOCIAL SECURITY NO. <u>?</u> | | 17. INFORMANT <u>PT.'S ER. SHEET & OLD CHART</u> | |
| 18. <u>412.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>PULMONARY EMBOLUS</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>HASCVD</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u> <u>1/2 S</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>8:20 AM 7/28</u> 19 <u>72</u> to <u>9:15 AM 7/28</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>JULY 28</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Meyer R. Heyman M.D.</u> DEGREE | | | | 23B. DATE SIGNED <u>7/28/72</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>M.R. HEYMAN M.D.</u> DEGREE | | | | 23D. ADDRESS <u>UNIV. OF MARYLAND HOSP.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>8/1/72</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Walt Whitman</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>MD</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 7 1972</u> | | 25B. NAME OF REGISTRAR <u>Sidney Shortz</u> | |
| 25C. FUNERAL DIRECTOR <u>Bliss</u> | | 25D. ADDRESS <u>Bliss, 1007 B... ..</u> | | | |



0-5601

72 07453 BALTIMORE CITY HEALTH DEPARTMENT

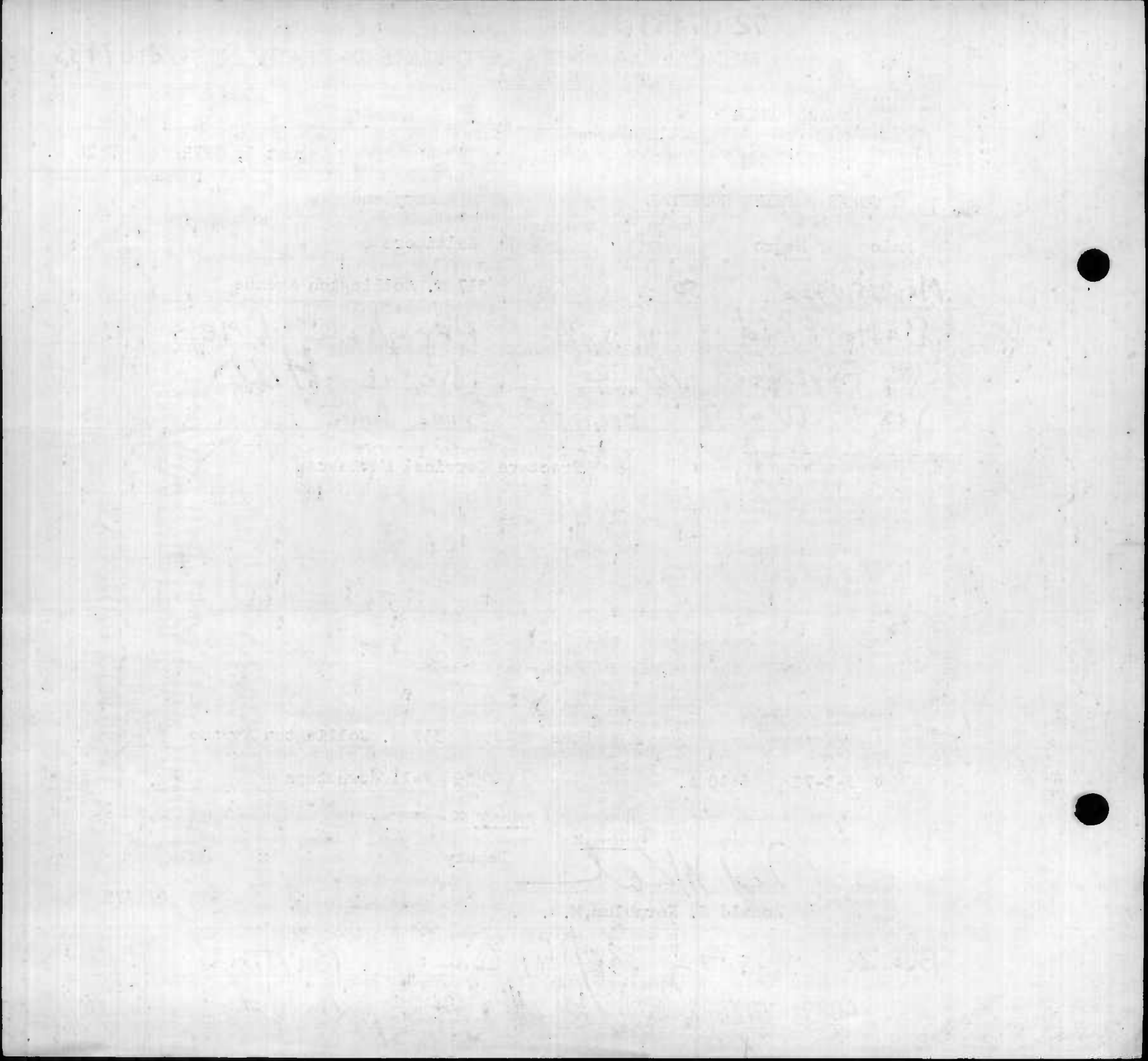
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07453 REG. NO.

BIRTH NO.

STATE OF MARYLAND-DEMH

| | | | | | | | |
|---|-------------------------|--|--|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) HOWARD OMER | | | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL | | | | 3. DATE PRONOUNCED DEAD Month Day Year Hour August 1, 1972 7:20 A. | | | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 703 | | | | | | | |
| 6. SEX Male | 7. RACE Negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH May 15, 1922 | | 10. AGE (In years last birthday) 50 | | E. STREET AND NUMBER 517 N. Collington Avenue | | | |
| 11. BIRTHPLACE (State or foreign country) Balto. Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Abraham Omer | | | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) City Employee | | 14B. KIND OF BUSINESS OR INDUSTRY None | | 15. MOTHER'S MAIDEN NAME Rosie Hill | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II | | 17. SOCIAL SECURITY NO. 214-18-5781 | | 18. INFORMANT Emma Omer | | ADDRESS 2207 E. Jefferson St. | |
| MEDICAL CERTIFICATION | | | | CAUSE OF DEATH | | | |
| | | | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Fracture Cervical Vertebra | | | |
| | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 20A. DATE OF OPERATION 8-5-72 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 21. AUTOPSY? (Yes or No) yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 517 N. Collington Avenue 703 | | | |
| 22D. TIME OF INJURY (APPROX.) 8-1-72 6:10 A. m. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Fell down steps | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: Ronald N. Kornblum, M.D. DATE SIGNED: 8/1/72 EXAMINER'S NAME (Type) | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-5-72 | | 24C. NAME of CEMETERY or CREMATORY Balto. Com. | | 24D. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 7 1972 | | 25B. NAME OF REGISTRAR Sidney Johnston | | 25C. FUNERAL DIRECTOR O. Wilson | | ADDRESS 1000 Brantley Ave. Balto. Md. | |



H 626

72 07454 BALTIMORE CITY HEALTH DEPARTMENT

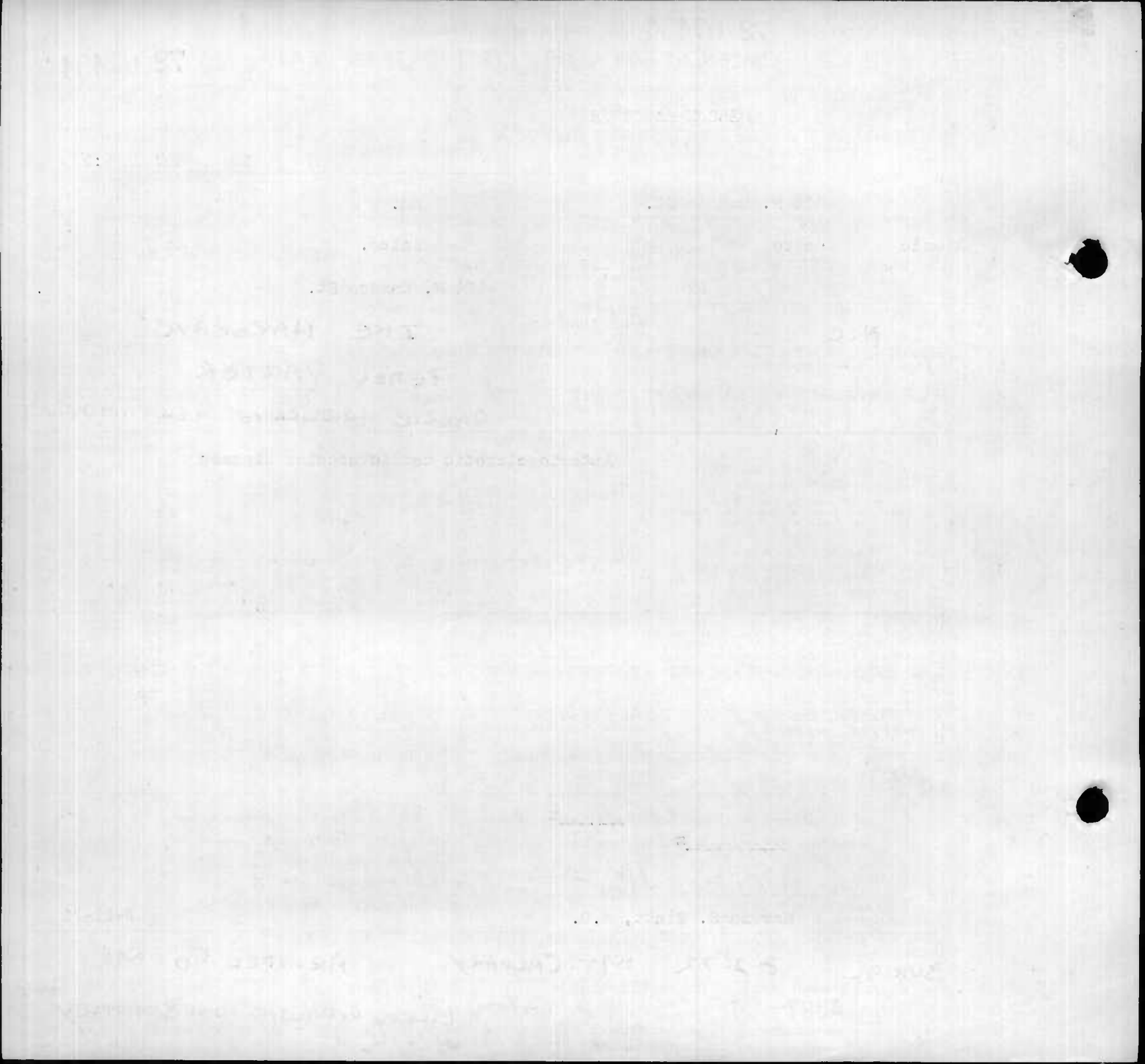
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND-DEMH

REG. NO. 72 07454

BIRTH NO.

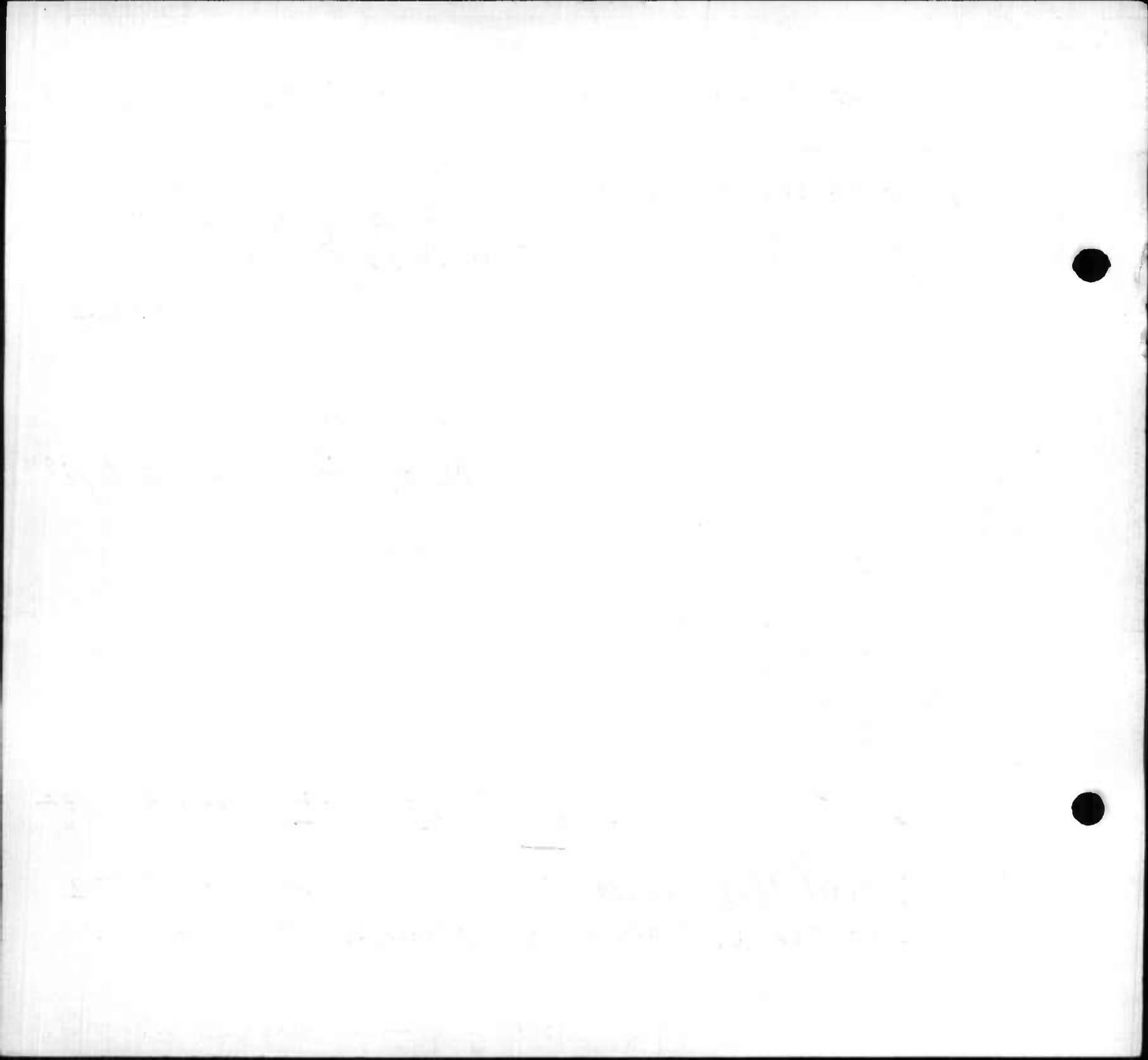
| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) WILSON HARGROVE | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 424 W. Camden St. | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 7 28 1972 6:25p M. | |
| 6. SEX male | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 7. RACE negro | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 10. AGE (In years last birthday) 62 | | E. STREET AND NUMBER 424 W. Camden St. | |
| 11. BIRTHPLACE (State or foreign country) N.C. | | 13. FATHER'S NAME IKE HARGRAVE | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 15. MOTHER'S MAIDEN NAME PEARL PARTER | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT CARRIE HARGRAVE | | ADDRESS 424 CAMDEN ST | |
| 19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | CAUSE OF DEATH Arteriosclerotic cardiovascular disease | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION 0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No) no | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. DATE SIGNED 7-29-72 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 8-2-72 | |
| 24C. NAME OF CEMETERY or CREMATORY MT CALVARY | | 24D. LOCATION (City, town, or county) (State) ARUNDEL CO Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 7 1972 | | 25B. NAME OF REGISTRAR Sidney Ingham | |
| 25C. FUNERAL DIRECTOR ELROY O. WILSON | | ADDRESS 1000 BRANTLEY AVE | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

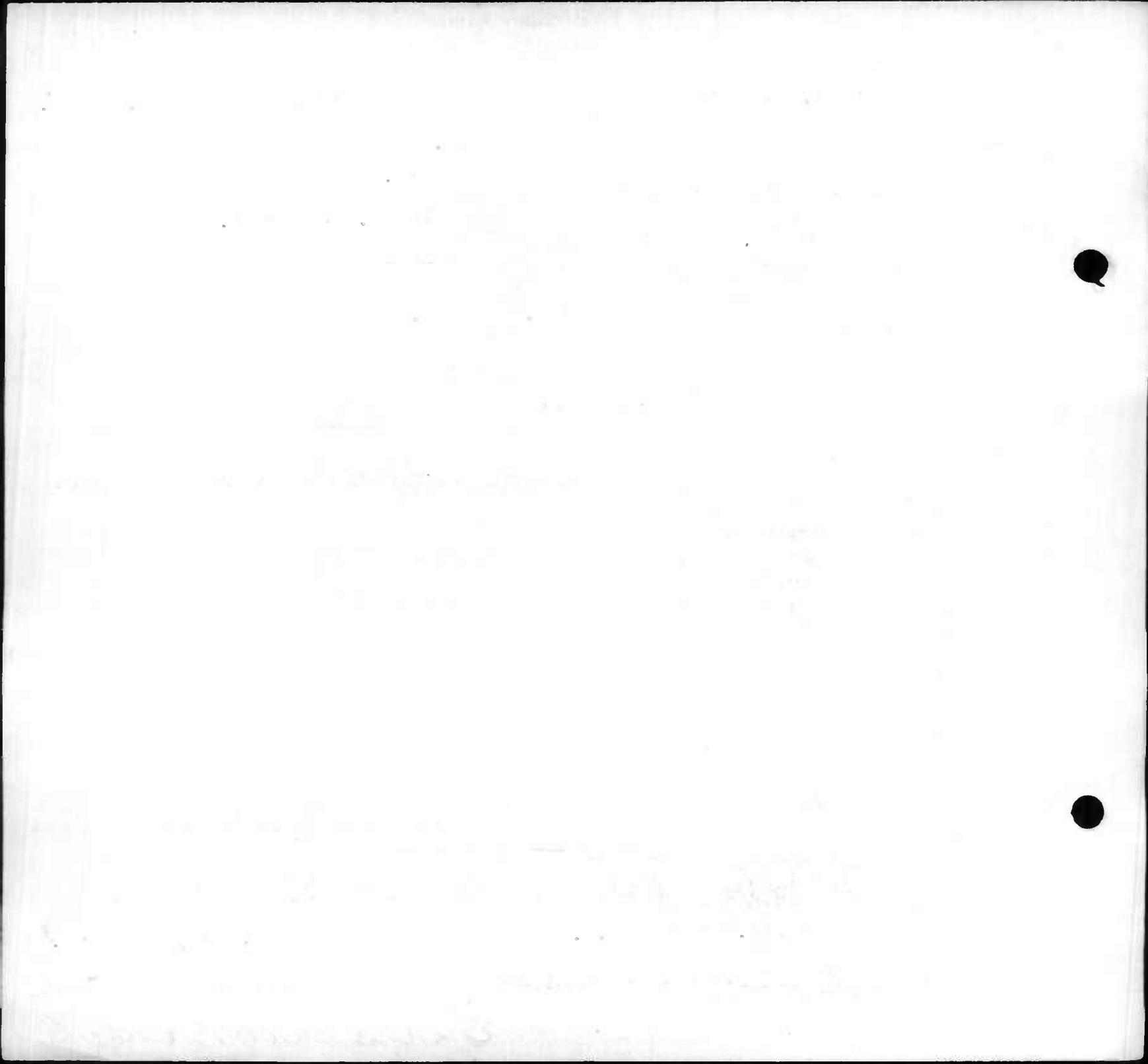
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07455 | |
|---|--|---|---|--|---|
| 72 07455 CERTIFICATE OF DEATH | | | | REG. NO. _____ | |
| BIRTH NO. _____ | | 1. NAME OF DECEASED (Type or Print) SARAH G. WESLEY | | 2. DATE AND HOUR OF DEATH 8-3-72 1 6⁰⁰ A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MONTEBELLO STATE Hospital | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 603 | | |
| 5. SEX F | | | 6. RACE B | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) South Carolina | |
| 13. FATHER'S NAME Samuel Wesley | | 14. MOTHER'S MAIDEN NAME Polly Roseboro | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 139-20-3773 | | 17. INFORMANT Willette Holmes ADDRESS same | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE Multiple Sclerosis DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 710 yrs | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from Jan 22, 1962 to Aug 3, 1972 that (we) last saw the deceased alive on 8-3-72 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Fredrick N. Pearson | | | | 23B. DATE SIGNED 8-3-72 | |
| 23C. PHYSICIAN'S NAME (Type) FREDERICK N. PEARSON, M.D. | | | | 23D. ADDRESS Montebello State Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 8-9-72 | | 24C. NAME of CEMETERY or CREMATORY Balto. Cem. | |
| 24D. LOCATION Balto. Md. | | 24E. DATE REC'D BY HEALTH DEPT. AUG 7 1972 | | 24F. NAME OF REGISTRAR Lindsey Thornton | |
| 24G. FUNERAL DIRECTOR Henry O. Wilson | | 24H. ADDRESS 1000 Brantley Ave. | | 24I. _____ | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

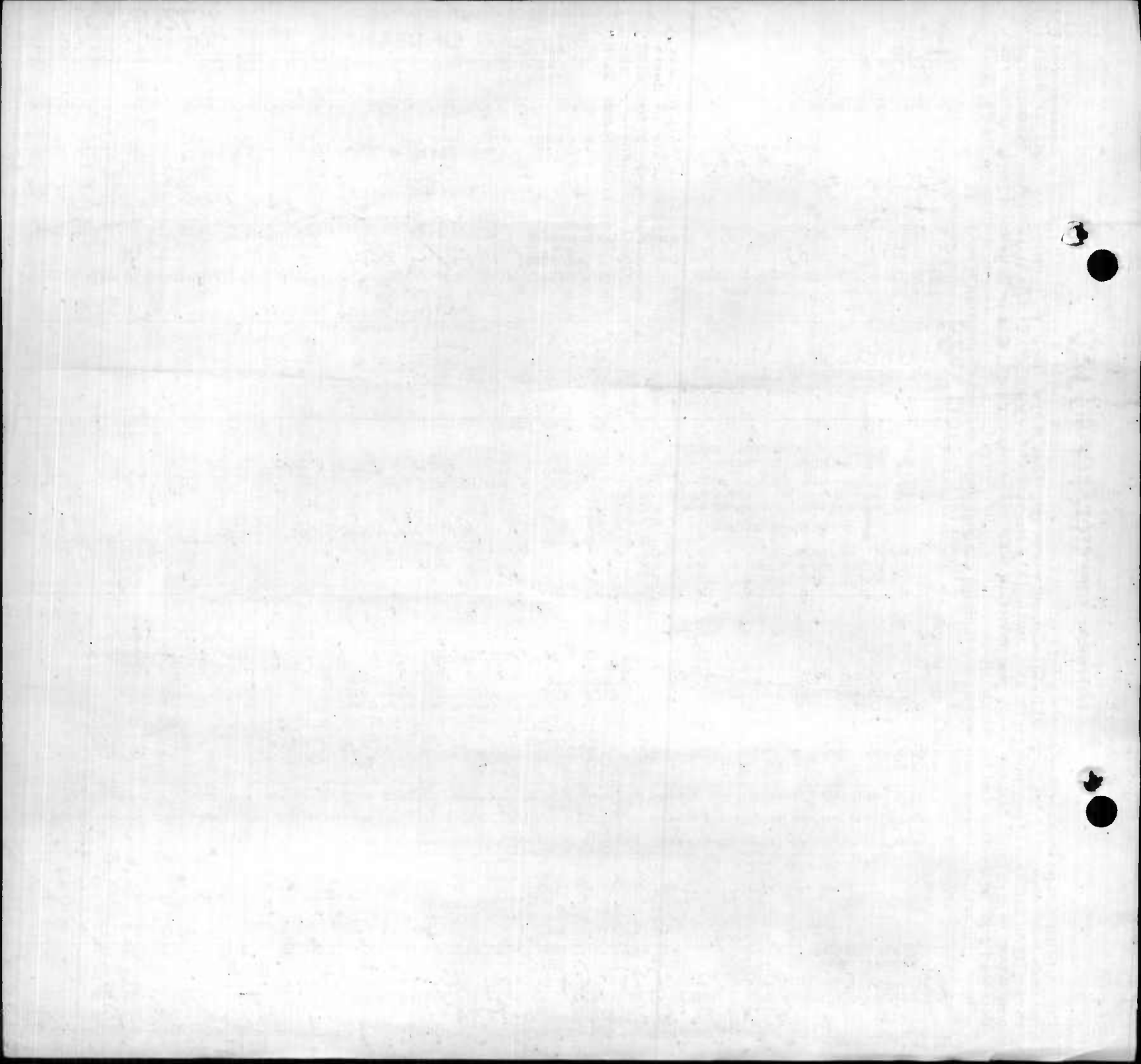
| BIRTH NO. 72 07456 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 72 07456 | | STATE OF MARYLAND-DEME | |
|--|-------------------------|--|--|---|--|--|------------------------------|
| 1. NAME OF DECEASED (Type or Print) <u>Hill, Preston</u> | | | | 2. DATE AND HOUR OF DEATH <u>7/28/72</u> <u>9:55</u> P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Good Samaritan Hospital</u> <u>45</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1004</u> | | | |
| | | | | C. CITY OR TOWN <u>Balto.</u> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER <u>510 E. Eager St.</u> | | | |
| 5. SEX <u>male</u> | 6. RACE <u>negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>08-29-05</u> | 9. AGE (in years last birthday) <u>67</u> | 11. Under 1 Yr. Months Days | 12. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Acme Box Comp.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>America</u> | |
| 13. FATHER'S NAME <u>—</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Laura Johnson</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>216-09-0268</u> | | 17. INFORMANT <u>Laura Hill</u> | | ADDRESS <u>—</u> | |
| 18. CAUSE OF DEATH <u>I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE <u>Carcinoma of stomach</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>—</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>—</u> | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION <u>06-23-72</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>stomach disease</u> | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>6/13</u> 19 <u>72</u> to <u>7/28</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>7/28</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Peter J. Tutschka M.D.</u> | | | | 23B. DATE SIGNED <u>7/28/72</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Peter J. Tutschka M.D.</u> | | | | 23D. ADDRESS <u>13 warren Lodge ct. 2c, Cockeysvl. Md</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Buried 8-2-72</u> | | 24B. DATE <u>8-2-72</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>MT AUBURN</u> | | 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, Md</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 7 1972</u> | | 25B. NAME OF REGISTRAR <u>—</u> | | 25C. FUNERAL DIRECTOR <u>—</u> | | ADDRESS <u>—</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07457 | |
|---|---------------------|---|--|--|--|
| BIRTH NO. | | | | STATE OF MARYLAND-DEMH | |
| 1. NAME OF DECEASED (Type or Print) <i>Mary Smith</i> | | | 2. DATE AND HOUR OF DEATH <i>8/1/72 8.15 P M.</i> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>South Baltimore General Hospital</i> <i>43</i> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>2562</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>829 Seagull Ave.</i> | | |
| 5. SEX <i>F</i> | 6. RACE <i>N</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>6/4/94</i> | 9. AGE (In years last birthday) <i>78</i> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i> |
| 13. FATHER'S NAME <i>William Jennings (dec.)</i> | | | 14. MOTHER'S MAIDEN NAME <i>Sophie (dec.)</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. <i>219 1005 12A</i> | | 17. INFORMANT ADDRESS |
| 18. <i>2562</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Pat. Embolism</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Rt. Femur fracture</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <i>7/25/72</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>hip fracture</i> | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>Yes</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>home</i> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>829 Seagull Ave. 2562</i> | |
| 21D. TIME OF INJURY (APPROX.) <i>July 19 72</i> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <i>fell down in the bathroom</i> | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>July 20th 1972</i> to <i>April 1st 1972</i> , that (I) (we) last saw the deceased alive on <i>April 1st 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Tong Sung Chang M.D.</i> | | | | 23B. DATE SIGNED <i>8/1/72</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Tong Sung CHANG M.D.</i> | | | | 23D. ADDRESS <i>South Baltimore General Hospital</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>8-8-72</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>MT. CALVARY CEM.</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Brooklyn Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>AUG 7 1972</i> | | | |
| 25B. NAME OF REGISTRAR <i>Andrew J. Houston</i> | | 25C. FUNERAL DIRECTOR <i>Charles O. Wilkins</i> | | | |
| 25D. ADDRESS <i>Baltimore, Md.</i> | | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07458 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

72 07458

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ABRONS

LUCIOUS

2. DATE AND HOUR OF DEATH

8/4/72

12:00a

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTIONIF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION

PROVIDENT HOSPITAL

2600 LIBERTY HEIGHTS AVENUE

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE

MD

C. CITY OR TOWN
BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2618 VIOLET AVENUE

5. SEX

MALE

6. RACE

BLACK

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

4/15/14

9. AGE (In years
last birthday)

58

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Lucious ABron Jr.

14. MOTHER'S MAIDEN NAME

Margana Mitchell

15. Was Deceased ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Lucious ABron Jr. 2618 Violet Ave.

ADDRESS

18. 250.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

C.V.A.

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

15 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

Diabetes Mellitus

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH Notify medical examiner21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8-4-72 to 8-5-72
 that (I) (we) last saw the deceased alive on 8-4-72 and that in (my) (our) opinion death occurred on the date
 and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Maurice A. Allen, Jr. M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

8-5-72

23C. PHYSICIAN'S
NAME (Type)

23D. ADDRESS

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8-8-72

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION

Baltimore

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 7 1972

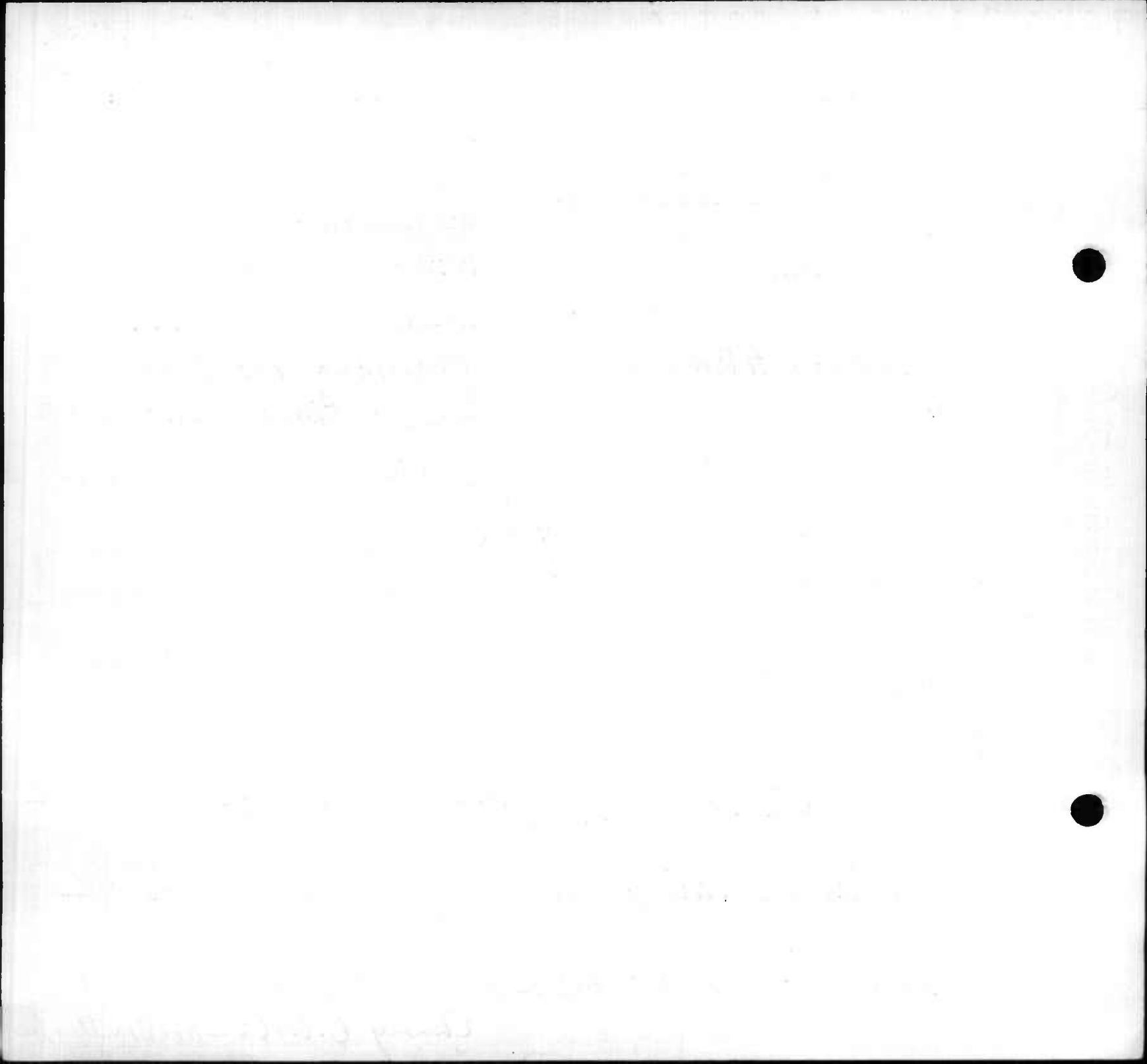
25B. NAME OF REGISTRAR

Sidney H. Weston

25C. FUNERAL DIRECTOR

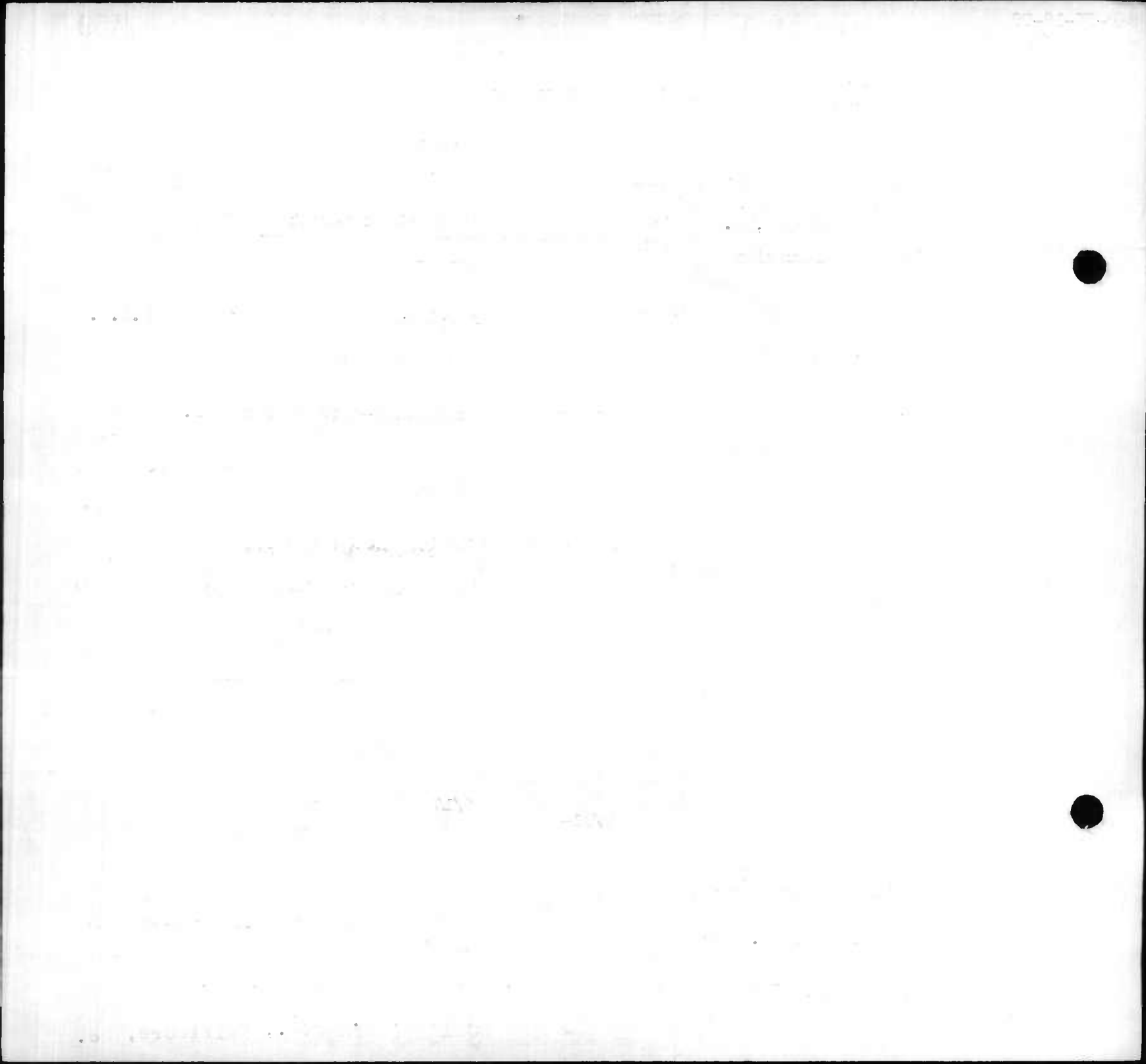
Garry D. Wilson 1000 Bentley Ave.

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

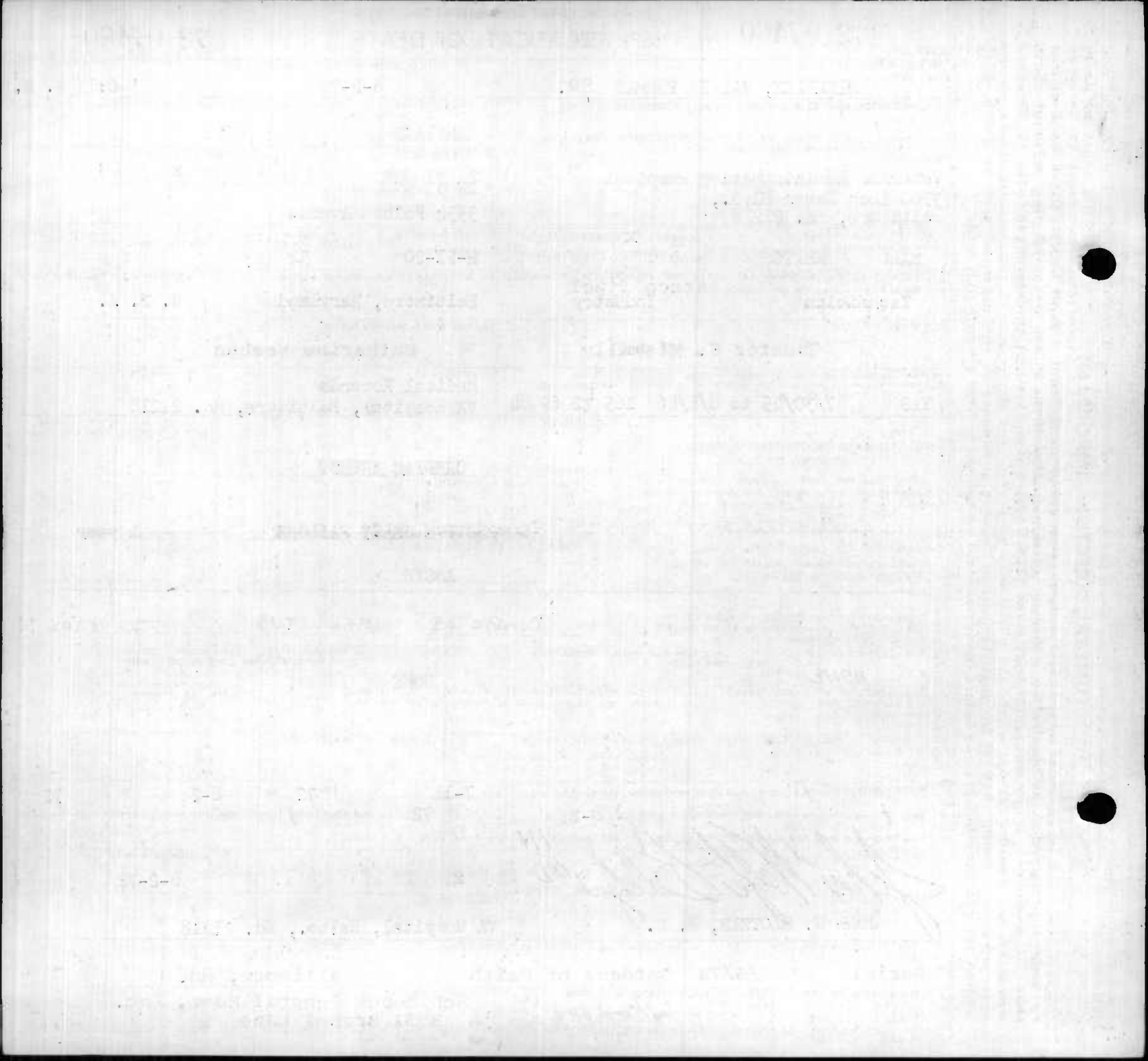
| | | | | | |
|--|-------------------|--|--------------------------|---|---|
| BIRTH NO. 72 07459 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07459 | |
| 1. NAME OF DECEASED (Type or Print) Brenner Clifton Harrison | | 2. DATE AND HOUR OF DEATH 7/31/1972 1:10 PM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Md. 21224 | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 102 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3104 Fleet Street 21224 | | | |
| 5. SEX Male | 6. RACE Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-25-14 | 9. AGE (In years last birthday) 58 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brewery worker | | 10B. KIND OF BUSINESS OR INDUSTRY Beer | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME John Brenner | | 14. MOTHER'S MAIDEN NAME Margaret Woelfle | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-09-1313 | | 17. INFORMANT ADDRESS Records: BCH-4940 Eastern Ave. 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE Uremic coma DUE TO, OR AS A CONSEQUENCE OF: (B) hepatic encephalopathy DUE TO, OR AS A CONSEQUENCE OF: (C) LLL pneumonia Seizure disorder | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 2 years 4 days | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) 1 (Month) (Day) 1 (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/17 19 72 to 7/31 19 72 that (I) (we) last saw the deceased alive on 7/31- 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Matthew N. Fine, M.D. | | 23B. DATE SIGNED 7/31/72 | | 23C. PHYSICIAN'S NAME (Type) Matthew N. Fine | |
| 23D. ADDRESS 4940 Eastern Ave., Baltimore City | | 23E. DEGREE Hospitals | | 23F. ADDRESS 4940 Eastern Ave., Baltimore City | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-3-72 | | 24C. NAME OF CEMETERY or CREMATORY Holly Hill Mem. Gardens | |
| 24D. LOCATION Baltimore, Md. | | 24E. DATE REC'D BY HEALTH DEPT. AUG 7 1972 | | 24F. NAME OF REGISTRAR Sydney [Signature] | |
| 24G. FUNERAL DIRECTOR Nicholas T. Matthews | | 24H. ADDRESS 3021 Eastern Ave., Baltimore, Md. | | 24I. ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

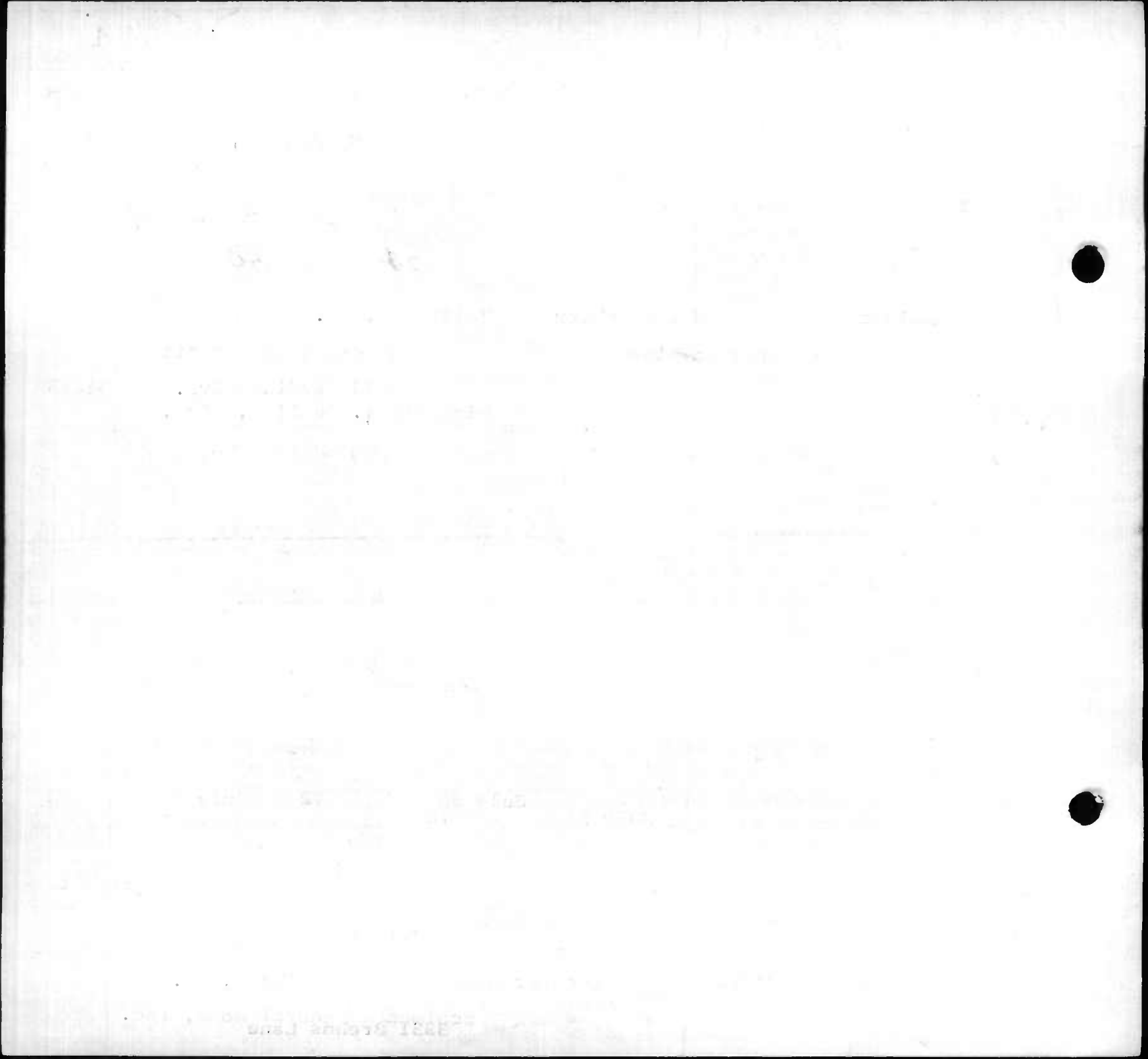
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|---|--|---|---|
| M-240 72 07460 BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 72 07460 STATE OF MARYLAND-DEM | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| MISKELLY, CALVIN THOMAS SR. | | | 8-2-72 6:15 A. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Blvd., Baltimore, Md. 21218 | | | A. STATE MARYLAND | | CITY 2633 |
| | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER 3534 Pelham Avenue | | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-21-20 | 9. AGE (In years last birthday) 52 | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Technician | | | 10B. KIND OF BUSINESS OR INDUSTRY Armco Steel Industry | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | |
| 13. FATHER'S NAME Chester F. Miskelly | | | 14. MOTHER'S MAIDEN NAME Katharine Meehan | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 7/30/45 to 8/8/46 | | | 16. SOCIAL SECURITY NO. 165 12 69 84 | | 17. INFORMANT Medical Records VA Hospital, Baltimore, Md. 21218 |
| 18. 412.4 4250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF: (B) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF: (C) ASCVD | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). DIABETES MELLITUS | | | | | 20 YEARS |
| 19A. DATE OF OPERATION D NONE | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NONE |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (y) (this hospital) attended the deceased from 7-11 19 72 to 8-2 19 72, that (y) (we) lost saw the deceased olive on 8-2 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (y) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE John W. Blotzer MD | | | | | 23B. DATE SIGNED 8-2-72 |
| 23C. PHYSICIAN'S NAME (Type) JOHN W. BLOTZER, M. D. | | | 23D. ADDRESS VA Hospital, Balto., Md. 21218 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/5/72 | 24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 7 1972 | | 25B. NAME OF REGISTRAR Sydney [Signature] | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

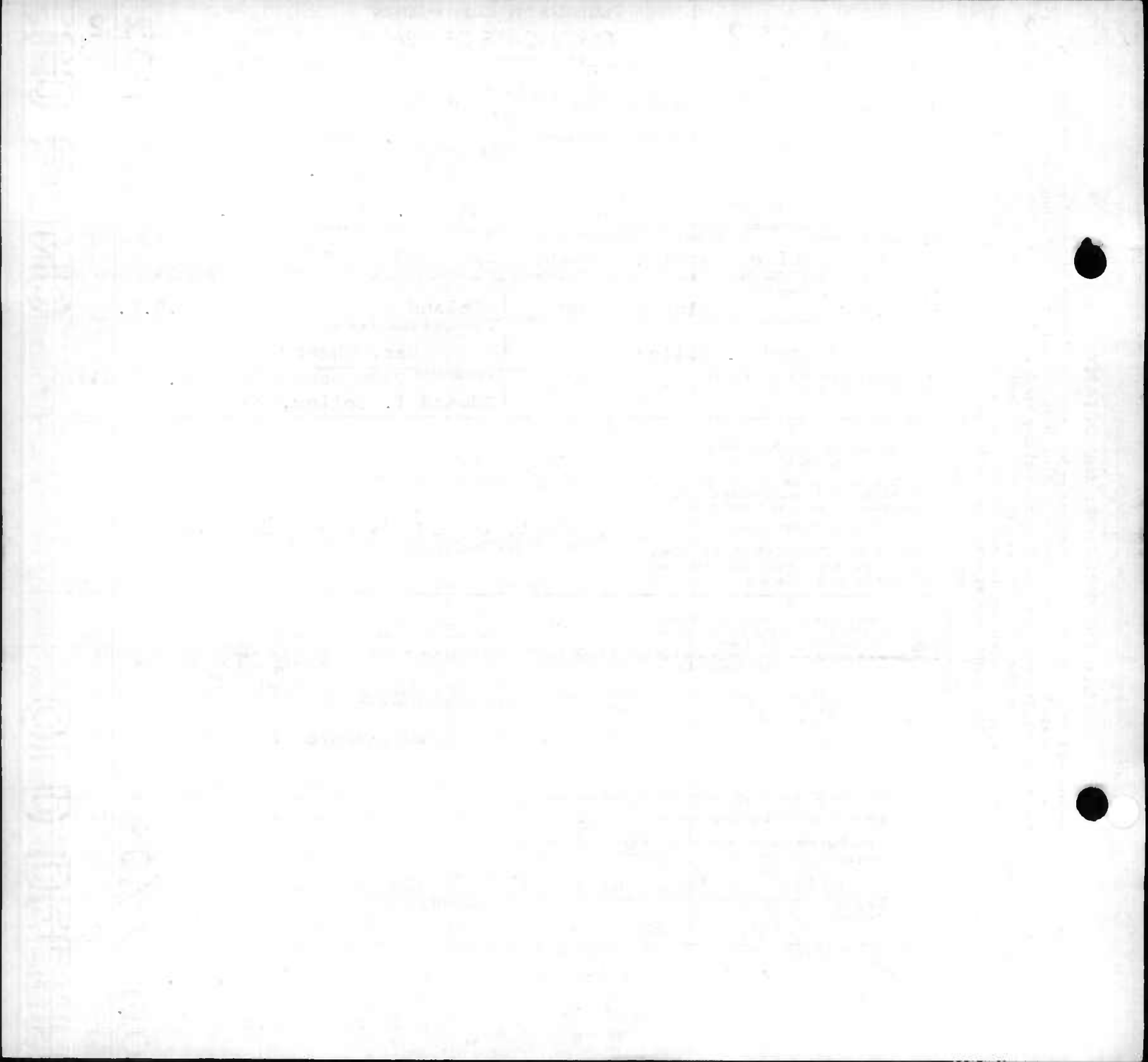
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07461 | |
|--|--|--|--|--|--|
| 72 07461 | | | | STATE OF MARYLAND-DEME | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | BENNINGTON, Mrs. MARY Alice | | 7/31/72 12:25 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | |
| Church Home & Hospital 100 North Broadway | | | | MD. BALTIMORE 201 | |
| 5. SEX F. 6. RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | C. CITY OR TOWN D. INSIDE CITY LIMITS? | |
| 8. DATE OF BIRTH 2/11/22 9. AGE (In years last birthday) 50 | | | | City YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY | | | | E. STREET AND NUMBER | |
| Helper H & S Bakery | | | | 1916 GOUGH ST. 21231 | |
| 13. FATHER'S NAME ? Harry Hawkins | | | | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 14. MOTHER'S MAIDEN NAME ? Kathleen Barrett | |
| 16. SOCIAL SECURITY NO. ? | | | | 17. INFORMANT 3012 Mayfield Ave. ADDRESS 21213 Michelle L. Aoulter, neice, | |
| 18. 400.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | |
| ANTECEDENT CAUSES | | | | Hypertension Encephalopathy | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Malignant Hypertension | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | (C) _____ | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 30 19 72 to July 31 19 72 that (I) (we) last saw the deceased alive on July 31 19 72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE A. Impagliatelli | | | | 23B. DATE SIGNED 7/31/72 | |
| 23C. PHYSICIAN'S NAME (Type) WALKER, A. IMPAGLIATELLI | | | | 23D. ADDRESS Church Home & Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 8/3/72 | | Holy Redeemer Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| AUG 7 1972 | | Schimunek Funeral Home, Inc. | | 3231 Brehms Lane | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>72 07462</u> | |
|---|-------------------------|---|--|---|---|
| BIRTH NO. <u>72 07462</u> | | | | STATE OF MARYLAND - DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>ESTHER Irene HOWARD</u> | | 2. DATE AND HOUR OF DEATH <u>7-30-72</u> <u>915</u> P. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2610</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>37 MERCY HOSPITAL</u> | | C. CITY OR TOWN <u>Baltimore, Md.</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER <u>XX 8 N. Highland Ave.</u> | | | | | |
| 5. SEX <u>female</u> | 6. RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2/6/1903</u> | 9. AGE (In years last birthday) <u>69</u> | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Blossom Shop</u> | | 11. BIRTHPLACE (State or foreign country) <u>Poland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | |
| 13. FATHER'S NAME <u>Richard T. Colley</u> | | | 14. MOTHER'S MAIDEN NAME <u>Mary Wheary</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>9406 Dana Vista Rd. ADDRESS 21236</u> <u>Edward 1. Colley, brother</u> | |
| 18. <u>519.3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Restrictive Pulmonary Disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Restrictive Pulmonary Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>Year</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Married ASCVD</u> | | | | | |
| 19A. DATE OF OPERATION <u>7/25</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u> | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7/25</u> 19 <u>72</u> to <u>7/30</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>7/30</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Tolhu ONE MD</u> | | | | 23B. DATE SIGNED <u>7/30/72</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Tolhu ONE MD</u> | | | | 23D. ADDRESS <u>Mercy Hospital, Baltimore, MD</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>8/3/72</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u> | |
| 24D. LOCATION <u>Baltimore, Md.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 7 1972</u> | | 25B. NAME OF REGISTRAR <u>Indy...</u> | | 25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> | |
| 25D. ADDRESS <u>3831 Brehms Lane</u> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07463 | |
|---|---------------|---|----------------------------------|--|--|
| 72 07463 | | | | STATE OF MARYLAND | |
| BIRTH NO. 0. | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | CLINTON ELLIOTT | | 2. DATE AND HOUR OF DEATH 08-02-72 4:55 P | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE MARYLAND | |
| THE JOHNS HOPKINS HOSPITAL | | | | B. COUNTY | |
| 33 | | | | C. CITY OR TOWN BALTIMORE | |
| | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 4833 WRIGHT AVE. | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-21-98 | 9. AGE (In years lost birthday) 73 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| retired-laborer | | Balto. City. | | Baltimore, Md. | |
| 13. FATHER'S NAME CHARLES ELLIOTT | | | 14. MOTHER'S MAIDEN NAME BLANCHE | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| yes Army WW2 | | 218-22-5629 | | Catherine Kutsner Elliott, wife, above | |
| 18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE ASCVD | |
| ANTECEDENT CAUSES | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) _____ | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 10 1972 to July 25 1972 that (I) (we) last saw the deceased alive on July 25 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert Friedman M.D. | | | | 23B. DATE SIGNED 8/2/72 | |
| 23C. PHYSICIAN'S NAME (Type) ROBERT FRIEDMAN M.D. | | | | 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/5/72 | | 24C. NAME OF CEMETERY or CREMATORY Dulany Valley Mausoleum | |
| | | | | 24D. LOCATION (City, town, or county) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 7 1972 | | 25B. NAME OF REGISTRAR Sidney Friedman | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3381 Brehms Lane | |

TT 21-43-122

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>72 07464</u> | |
|--|--|--|--|---|--|
| 72 07464 | | | | BIRTH NO. | |
| 72 07464 | | | | BIRTH NO. | |
| 1. NAME OF DECEASED (Type or Print) <u>Herrmann Regina Agatha</u> | | | | 2. DATE AND HOUR OF DEATH <u>August 2, 1972 8:00 P</u> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHEN PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>701</u> | |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital</u> <u>333</u> | | | | 6. CITY OR TOWN <u>BALTIMORE</u> | |
| 7. STREET AND NUMBER <u>3007 E. Monument St.</u> | | | | 8. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 9. SEX <u>female</u> | | 10. RACE <u>white</u> | | 11. DATE OF BIRTH <u>4/18/1908</u> | |
| 12. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 13. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 14. AGE (In years last birthday) <u>64</u> | |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u> | | 16. KIND OF BUSINESS OR INDUSTRY <u>Hutzler Bros.</u> | | 17. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | |
| 18. FATHER'S NAME <u>George Krieger</u> | | | | 19. MOTHER'S MAIDEN NAME <u>unknown Rosa Kidd</u> | |
| 20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>220-38-5149</u> | | | | 21. SOCIAL SECURITY NO. <u>220-38-5149</u> | |
| 22. INFORMANT <u>Herrmann</u> | | | | 23. ADDRESS <u>Frederick Herrmann, husband, above</u> | |
| 24. CAUSE OF DEATH <u>250.9 I</u> | | | | 25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs.</u> | |
| 26. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u> | | | | 27. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>10 yrs.</u> | |
| 28. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Diabetes Mellitus</u> | | | | 29. (B) DUE TO, OR AS A CONSEQUENCE OF: <u>10 yrs.</u> | |
| 30. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | 31. (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 32. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>August 2</u> 19 <u>72</u> to <u>August 2</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>August 2</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (<u>did</u>) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Harry R. Jacobson</u> | | | | 23B. DATE SIGNED <u>August 2, 1972</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>HARRY R. JACOBSON, M.D.</u> | | | | 23D. ADDRESS <u>Apt. 511 550 N Broadway Balt. Md. 21205</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>8/5/72</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u> | |
| 24D. LOCATION <u>Baltimore, Md.</u> | | 24E. CITY, town, or county | | 24F. (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 7 1972</u> | | 25B. NAME OF REGISTRAR <u>Sidney</u> | | 25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> | |
| 25D. ADDRESS <u>43331 Brehms Lane</u> | | 25E. CITY, town, or county | | 25F. (State) | |

8-22-1972 - Correction form from Funeral Home, Schimunek Funeral Home, Inc., Balto., Md.
by Hilda S. Rodgers, Secy. HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 72 07465 | | CITY OF BALTIMORE HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 72 07465 | |
|--|-----------------------------|---|--|--|---|
| 1. NAME OF DECEASED (Type or Print) SLACUM, MELVIN G. | | | 2. DATE AND HOUR OF DEATH AUGUST 3 1972 2:15PM | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY BALTO. C. CITY OR TOWN HALETHORPE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 4602 WASHINGTON BLVD. BALTO MD 21227 | | |
| 5. SEX MALE | 6. RACE CAUCASIAN | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-25-06 | 9. AGE (In years last birthday) 65 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED GROCER | | 10B. KIND OF BUSINESS OR INDUSTRY Self Employed | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? UNITED STATES |
| 13. FATHER'S NAME CHARLES SLACUM | | | 14. MOTHER'S MAIDEN NAME ANNIE SLACUM (NAVY) | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 212074155A | 17. INFORMANT CATON AVE. ST. AGNES HOSPITAL-RECORDS WILKENS & | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) TERMINAL METASTATIC CARCINOMA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARCINOMA - LUNG (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JULY 10 1972 to AUGUST 3 1972 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on AUGUST 3 1972 and that in (my) XX (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death. | | | | | |
| 23A. SIGNATURE Donato A. Vargas Jr. M.D. | | | | 23B. DATE SIGNED 8-3-72 | |
| 23C. PHYSICIAN'S NAME (Type) DONATO A. VARGAS, JR. | | | | 23D. ADDRESS BALTIMORE, MD. 21229 ST HOSPITAL (AGNES) CATON & WILKENS AVE. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-7-1972 | | 24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Wash. Blvd. Howard Co., Md. | | 25A. DATE REC'D BY HEALTH DEPT. AUG 7 1972 | | | |
| 25B. NAME OF REGISTRAR Howard H. Hubbard | | 25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | |

21 10591741 9208 12

19-435

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | REG. NO. | |
|--|--|--|--|---|--|--|--|
| 72 07466 | | | | | | 72-07466 | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| Leona L. Milton | | | | 7/30/72 6:40 pm | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | | | |
| 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | Maryland Baltimore | | | |
| 5. SEX | | | | 6. RACE | | 7. MARRIED | |
| Female | | Caucasian | | NEVER MARRIED | | WIDOWED | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| HOUSEWIFE | | | | | | MARYLAND | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| STEPHAN GRABOWSKI | | | | BERTHA SZYMANSKI | | | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | | | BCH Records 4940 Eastern Ave. 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| I This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 0 | | | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6-26 1972 to 7-30 1972 that (I) (we) last saw the deceased alive on 7-30 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Herbert G. Markley M.D. | | | | 7/30/72 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Herbert G. Markley M.D. | | | | 4940 Eastern Ave. Baltimore City Hospitals Balto. Md. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | | 8/3/72 | | Holy Rosary Cemetery | | BALTIMORE MD | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| AUG 7 1972 | | Sidney H. Hinton | | Raymond H. Kaczorowski | | 2525 Fleet St. | |

Handwritten text, possibly a signature or date, located in the upper left quadrant.

Handwritten text, possibly a signature or date, located in the center-left area.

Handwritten text, possibly a signature or date, located in the lower left area.

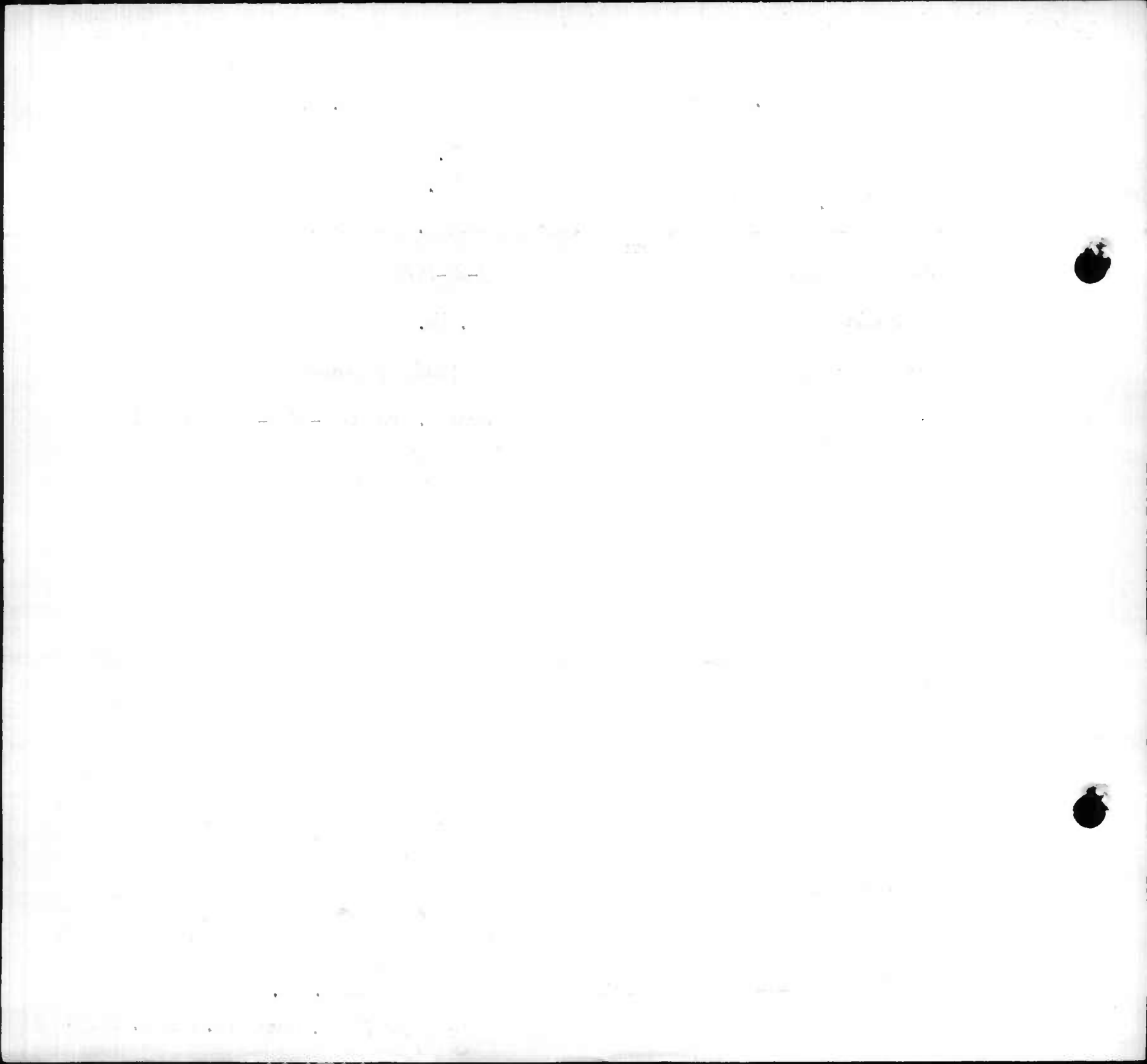
Handwritten text, possibly a signature or date, located in the lower left area.

Handwritten text, possibly a signature or date, located in the lower center area.

Handwritten text, possibly a signature or date, located in the lower right area.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

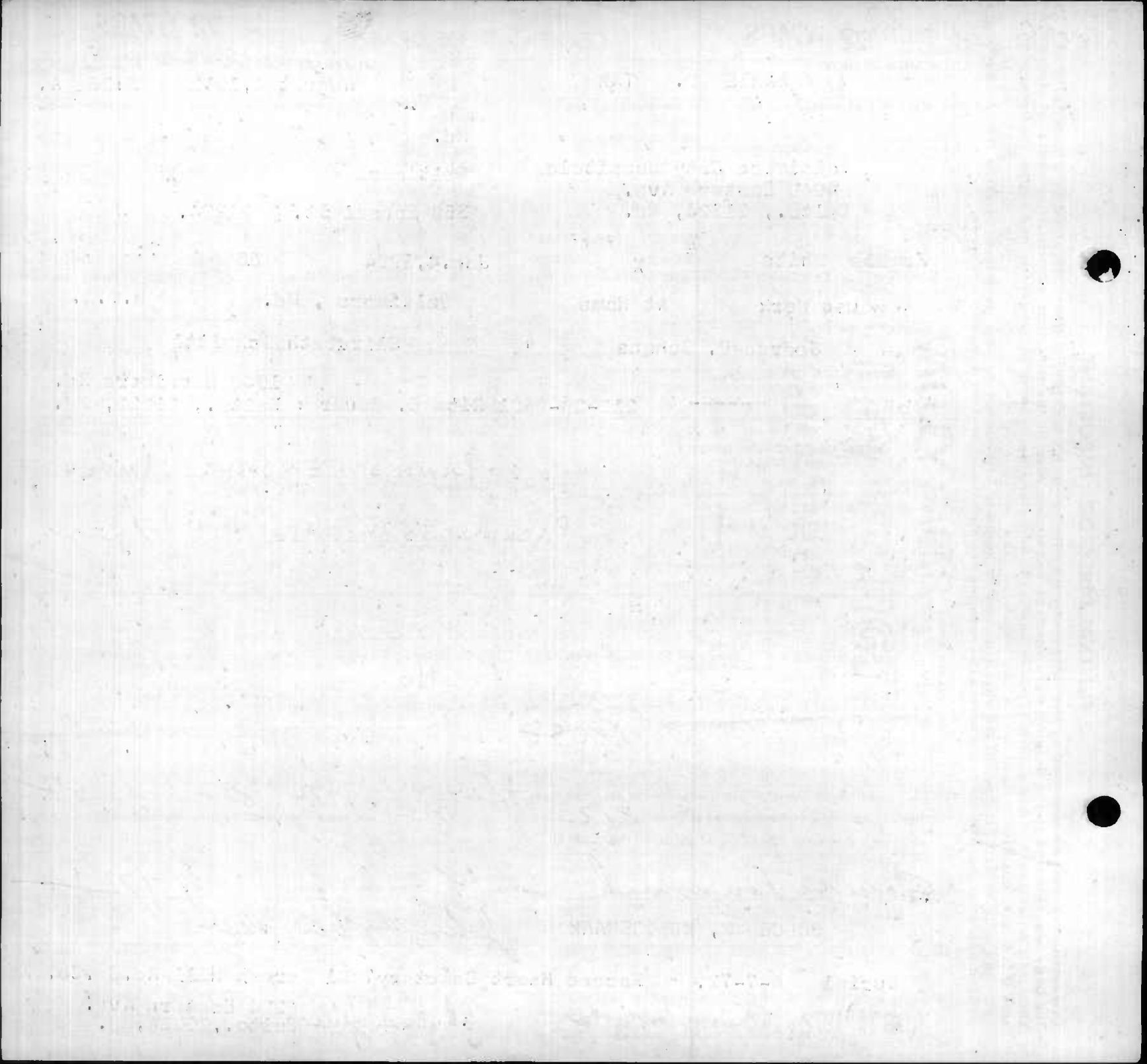
| | | | | | |
|---|--|--|--|---|--|
| 72 07467 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | REG. NO. 72 07467 | |
| 1. NAME OF DECEASED (Type or Print) <u>Conrad B. Gregory</u> | | 2. DATE AND HOUR OF DEATH <u>Aug. 1, 1972</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>210 E. Churchill Street</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2201</u> | | | |
| 5. SEX <u>Male</u> | | 6. RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housepainter</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH <u>3-28-1917</u> | |
| 13. FATHER'S NAME <u>Newton Gregory</u> | | 14. MOTHER'S MAIDEN NAME <u>Viola (Grave)</u> | | 9. AGE (In years last birthday) <u>55</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 11. BIRTHPLACE (State or foreign country) <u>W. Va.</u> | |
| 17. INFORMANT <u>Mary E. Gregory - wife - same as # 4</u> | | ADDRESS | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>153.8 I</u> <u>Maternal fat embolism</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>gth color</u> | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>gth color</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1972</u> to <u>Aug 1, 1972</u> that (I) (we) last saw the deceased alive on <u>June 6, 1972</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>[Signature]</u> | | 23B. DATE SIGNED <u>8/4/72</u> | | 23C. PHYSICIAN'S NAME (Type) <u>JUAN CARLOS LOZADA</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>8-4-72</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u> | | 25A. DATE RECEIVED BY HEALTH DEPT. <u>AUG 7 1972</u> | | 25B. NAME OF REGISTRAR <u>[Signature]</u> | |
| 25C. FUNERAL DIRECTOR <u>Mc Cully</u> | | ADDRESS <u>139 E. Font Ave. Balto. 21230</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07468 | |
|--|------------------|---|--|---------------------------------------|---|
| BIRTH NO. 72 07468 | | | | STATE OF MARYLAND - DEPT. OF HEALTH | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| MARIE D. PTAK | | | August 4, 1972 6:35 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Ave. Balto., 21224, Md. | | | A. STATE Md. B. COUNTY 2605 | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work | | | E. STREET AND NUMBER 359 Bonsal St. # 21224. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 4, 1904 | 9. AGE (In years last birthday) 68 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10B. KIND OF BUSINESS OR INDUSTRY At Home | | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME George V. Schane | | | 14. MOTHER'S MAIDEN NAME Elizabeth Schmittl | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 212-28-0801 | | 17. INFORMANT 1940 Haselmore Rd. Rita E. Bauer : Balto., 21222, Md. |
| 18. 342X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PULMONARY EMBOLUS IMMEDIATE (B) PARKINSON'S DISEASE 7 yrs. (C) | | |
| 19A. DATE OF OPERATION 0 - | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 7/24 1972 to 8/2/ 1972, that (I) was lost saw the deceased alive on 8/2 1972 and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) was (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Bruce W. Konigsmark | | | 23B. DATE SIGNED 8/5/72 | | 23C. PHYSICIAN'S NAME (Type) BRUCE W. KONIGSMARK |
| 23D. ADDRESS Johnston House | | | 23E. FUNERAL DIRECTOR Charles S. Seiler | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 8-7-72. | | 24C. NAME OF CEMETERY or CREMATORY Sacred Heart Cemetery |
| 24D. LOCATION 7401 German Hill Rd. Ba. Co., Md. | | | 25A. DATE REC'D BY HEALTH DEPT. AUG 7 1972 | | |
| 25B. NAME OF REGISTRAR Sidney Johnston | | | 25C. ADDRESS 6224 Eastern Ave. Balto., 21224, Md. | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>72 07469</u> | |
|---|---------------------|---|--|---|--|
| BIRTH NO. <u>72 07469</u> | | | | STATE OF MARYLAND - DEPT. OF HEALTH | |
| 1. NAME OF DECEASED (Type or Print) <u>HARTMAN, GEORGE</u> | | | 2. DATE AND HOUR OF DEATH <u>8-4-72 12:15 PM</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 UNION MEMORIAL HOSPITAL</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1412 MARSHALL ST.</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-07-95</u> | 9. AGE (In years last birthday) <u>76</u> | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Supt. Naval Gun Factory</u> | | | 11. BIRTHPLACE (State or foreign country) <u>MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>UNKNOWN</u> | | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes WW I</u> | | | 16. SOCIAL SECURITY NO. <u>unknown</u> | | 17. INFORMANT <u>Caroline E. Hartman 1412 Marshall Street</u> |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>Nov. 4, 1970</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Rather standable</u> 20A. AUTOPSY? (Yes or No) <u>No</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <u>June 6, 1972</u> to <u>August 4, 1972</u> , that (I) we lost saw the deceased alive on <u>August 4, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) We (did) (did not) view the body after death. 23A. SIGNATURE <u>[Signature]</u> DEGREE 23B. DATE SIGNED <u>August 4 '72</u> 23C. PHYSICIAN'S NAME (Type) <u>CHAU-WEN HSIAO, M.D.</u> DEGREE 23D. ADDRESS <u>The Union Memorial Hospital</u> 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 24B. DATE <u>8/7/72</u> 24C. NAME OF CEMETERY or CREMATORY <u>Cedar Hill Cemetery</u> 24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u> 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 7 1972</u> 25B. NAME OF REGISTRAR <u>Audrey [Signature]</u> 25C. FUNERAL DIRECTOR <u>Mc Cully Funeral Home 130 E. Fort Ave.</u> | | | | | |

100-100000

CERTIFICATE OF DEATH

REG. NO. 72 07470

STATE OF MARYLAND - DEPT. OF HEALTH

BIRTH NO. 72 07470

1. NAME OF DECEASED (Type or Print)

Joseph R. Shifflett SR.

2. DATE AND HOUR OF DEATH

10:00 pm 8/2/72 M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

31 BALTIMORE CITY HOSPITAL

4940 Eastern Ave., Baltimore, Md. 21224

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE B. COUNTY MARYLAND Baltimore

C. CITY OR TOWN D. INSIDE CITY LIMITS?

ESSEX YES NO

E. STREET AND NUMBER BOX 462 R216 21220

5. SEX

Male

6. RACE

Caucasian

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

9/17/1919

9. AGE (In years last birthday)

52

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Carpenter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Charlottesville, Va.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

JOSEPH SHIFFLETT

14. MOTHER'S MAIDEN NAME

Rose Roberts

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service)

YES

II

16. SOCIAL SECURITY NO.

217-03-4289

17. INFORMANT

Records: BCH-4940 Eastern Ave. 21224 William J. COSDEN 744 LANVERTON RD.

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

Cardiac Standstill

DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

Cancer of lung.

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 1/2 years

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At Work Not White At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/31/72 19 to 8/2/72 19 that (I) (we) last saw the deceased alive on 8/2/72 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Philip L. Smith

Attending Phys. Med. Director Staff Phys.

23B. DATE SIGNED

8/2/72

23C. PHYSICIAN'S NAME (Type)

Philip L. Smith

23D. ADDRESS

BALTIMORE CITY HOSPITAL 4940 Eastern Ave., Baltimore, Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

8/5/72

24C. NAME OF CEMETERY or CREMATORY

HOLLY HILL

24D. LOCATION (City, town, or county) (State)

BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.

AUG 7 1972

25B. NAME OF REGISTRAR

Andrew J. Harkness

25C. FUNERAL DIRECTOR

J. G. CONNELLY

ADDRESS

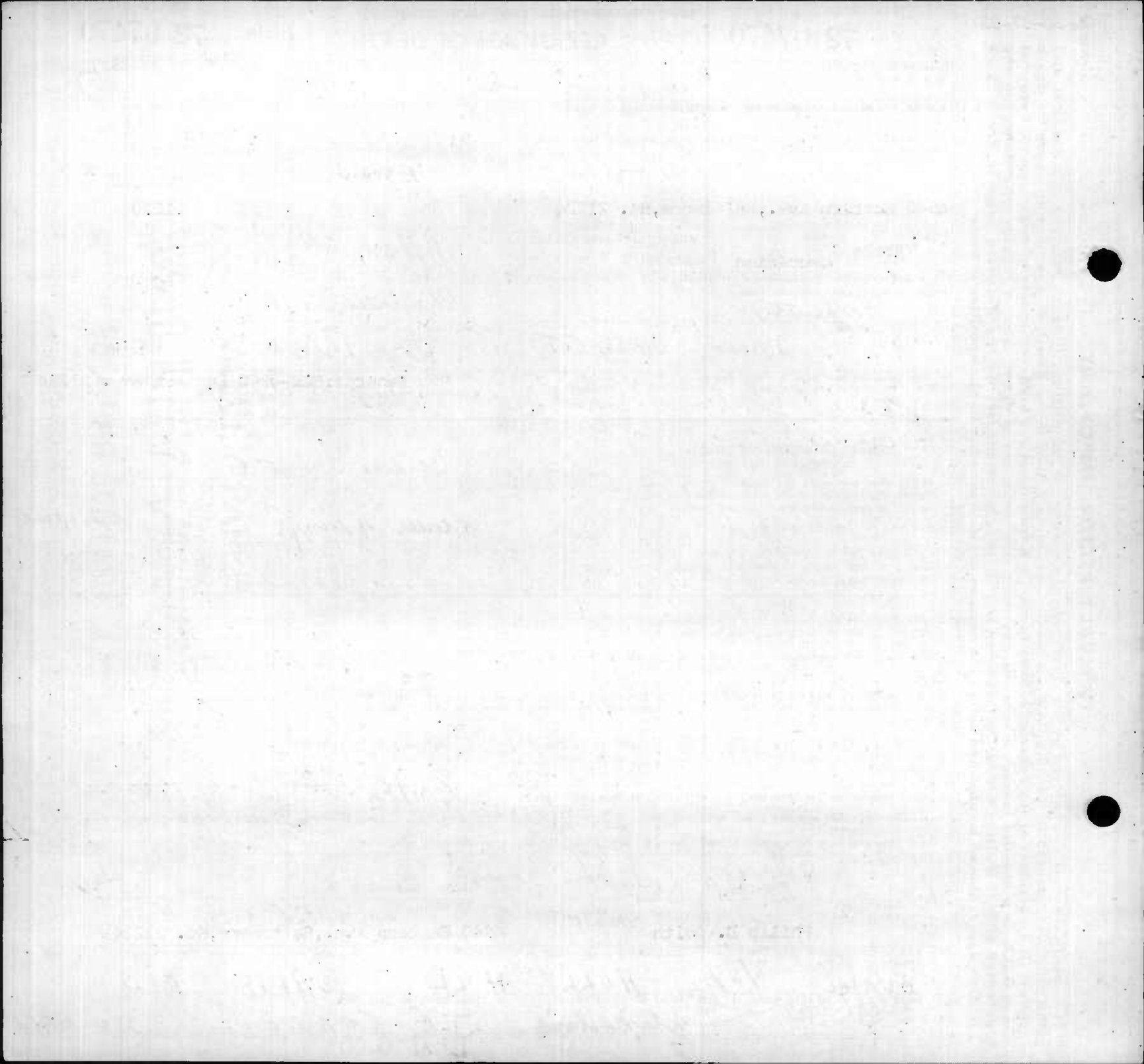
300 MACE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

S-143

167200073466



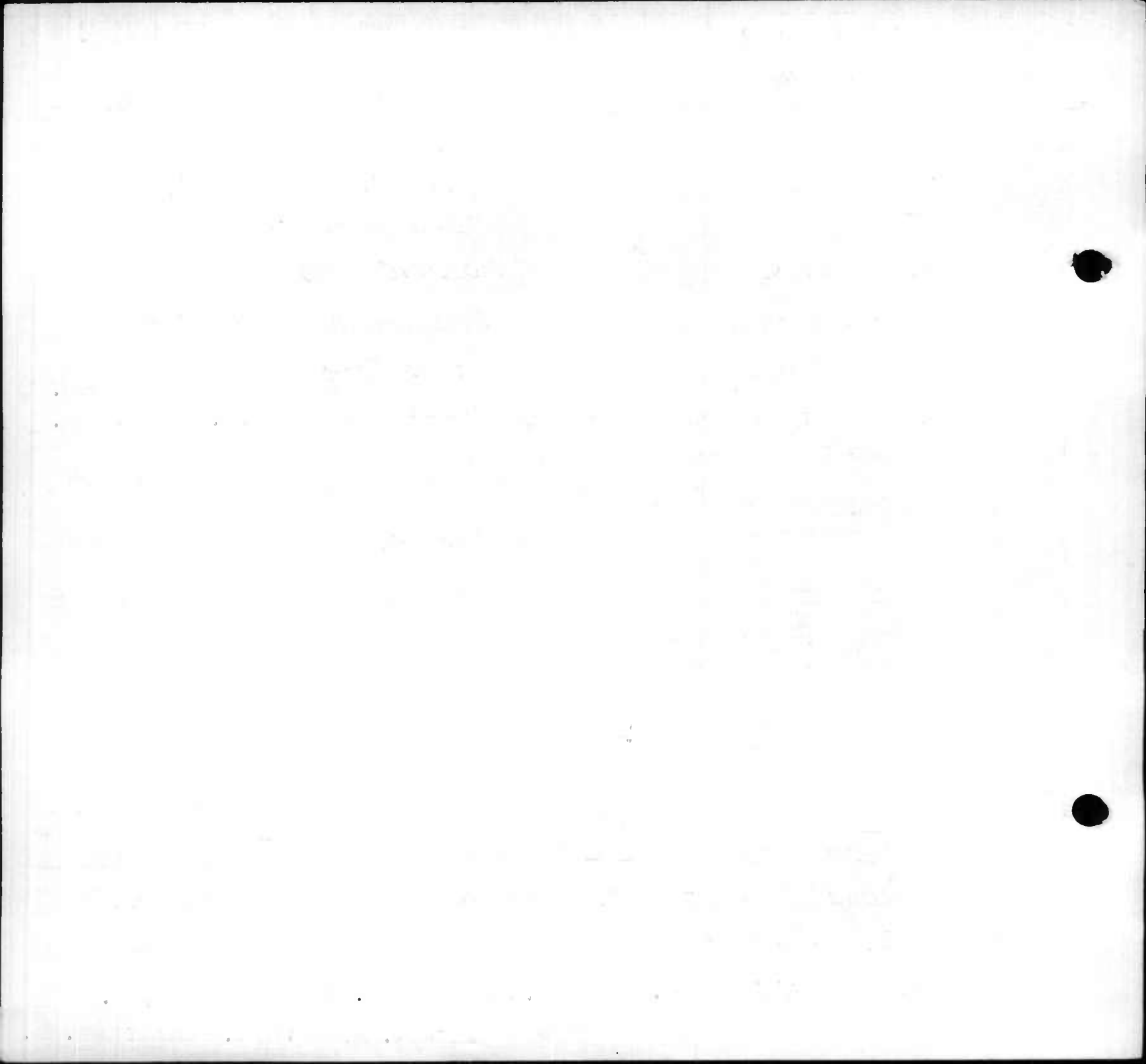
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|--|----------|--|---|--|---|--|
| N-550 1 | | 72 07471 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07471 | |
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) IDA J. NEWMAN | | | | 2. DATE AND HOUR OF DEATH 8/5/72 3:10 PM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION S. BALTIMORE GEN HOSP 4300 TOWNSEND ST. BALTIMORE MARYLAND | | | | A. STATE MARYD B. COUNTY AA | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX F | | | | 6. RACE N | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH 7/25/29 | |
| 13. FATHER'S NAME DAVID JONES | | | | 14. MOTHER'S MAIDEN NAME ELIZABETH JONES | | 9. AGE (In years last birthday) 79 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. 27-03-10889 | | 11. BIRTHPLACE (State or foreign country) VA. North Carolina | |
| 17. INFORMANT Beatrice Willard | | | | 12. CITIZEN OF WHAT COUNTRY? AMERICA | | | |
| 18. 453X1 | | | | ADDRESS 4401 Elizabeth Road | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PULMONARY EMBOLISM | | | |
| | | | | (B) DEEP VEIN THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (C) | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/24/72 to 8/5/72 that (I) (we) lost saw the deceased alive on 8/5/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Bo Keffe | | | | 23B. DATE SIGNED 8/5/72 | | 23C. PHYSICIAN'S NAME (Type) Bo Keffe | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 8/9/72 | | 24C. NAME OF CEMETERY OR CREMATORY Norton Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 7 1972 | | | | 25B. NAME OF REGISTRAR Shirley Norton | | 25C. FUNERAL DIRECTOR Mc Gully Funeral Homes | |
| | | | | 24D. LOCATION (City, town, or county) (State) Norton Virginia | | ADDRESS 130 E. Fort Ave. Balto. | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07472 | | REG. NO. 72 07472 | |
|--|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | STATE OF MARYLAND-DEPT. OF HEALTH | | | |
| BIRTH NO. 72 07472 | | 1. NAME OF DECEASED (Type or Print) <u>James Finney</u> | | 2. DATE AND HOUR OF DEATH <u>4 August 1972</u> <u>11:30 A.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Good Samaritan Hospital</u> <u>45</u> | | | | A. STATE <u>Maryland</u> B. COUNTY <u>908</u> | | | |
| 5. SEX <u>M</u> | | 6. RACE <u>Black</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>31 Dec 1895</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance man</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (in years last birthday) <u>76</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u> | |
| 13. FATHER'S NAME <u>Andrew Finney</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sarah Forgue</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>WWI</u> <u>1917-1918</u> | | 16. SOCIAL SECURITY NO. <u>215-01-0873</u> | | 17. INFORMANT <u>LUCRETIA WASHINGTON</u> ADDRESS <u>BALT. MD</u> <u>WASHINGTON 2807 W. LAFAYETTE AVE.</u> | | | |
| 18. <u>185X I</u> CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cancer of Lung</u> | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | <u>One Month</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) <u>Cancer of Prostate</u> DUE TO, OR AS A CONSEQUENCE OF: | | <u>Two Years</u> | |
| (C) _____ | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Specify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7-15</u> <u>1972</u> to <u>4 Aug</u> <u>1972</u> that (I) (we) last saw the deceased alive on <u>4 Aug</u> <u>1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>John D. Talbert, MD.</u> | | | | 23B. DATE SIGNED <u>4 Aug 72</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>John D. Talbert MD.</u> | | | | 23D. ADDRESS <u>5601 Loch Raven Blvd. Balto. Md. 21239</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>8/9/72</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>MT. AUBURN CEMETARY</u> | | 24D. LOCATION (City, town, or county) (State) <u>MT. WINNANS BALTIMORE, MD.</u> | |
| 25A. DATE REC'D. BY HEALTH DEPT. <u>AUG 7 1972</u> | | 25B. NAME OF REGISTRAR <u>Adrian Houston</u> | | 25C. FUNERAL DIRECTOR <u>WILLIAM G. SPICER</u> | | ADDRESS <u>1639 N. BROADWAY BALT. MD.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|----------------------|---|---|---------------------------------------|---|--|---|--|--|
| 72 07473 | | | | | REG. NO. 72 07473 | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| BIRTH NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) LONGWORTH, (PERRY) JOSEPH PERRINGTON | | | | | 2. DATE AND HOUR OF DEATH AUGUST 3, 1972 XX:20P M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL | | | | | MARYLAND ANNE ARUNDEL CO. 5200 | | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | | C. CITY OR TOWN D. INSIDE CITY LIMITS? LINTHICUM HGHTS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| | | | | | E. STREET AND NUMBER 416 CLEVELAND RD | | | | |
| 5. SEX MALE | 6. RACE CAUCASIAN | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 02 14 89 | 9. AGE (In years last birthday) 83 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONSTRUCTION | | | 10B. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION | | 11. BIRTHPLACE (State or foreign country) NEW YORK | | 12. CITIZEN OF WHAT COUNTRY? UNITED STATES | | |
| 13. FATHER'S NAME NOT KNOWN | | | | | 14. MOTHER'S MAIDEN NAME NOT KNOWN | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 216-03-7172 | | 17. INFORMANT WILKENS & CATON AVE. ST. AGNES HOSPITAL RECORDS | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 436.9 14011.9 (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: possible CVA (B) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) Heart failure Dementia. H/o T.B | | | | |
| 19. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (X) (this hospital) attended the deceased from AUGUST 2 19 72 to AUGUST 3 19 72, that (X) (we) last saw the deceased alive on AUGUST 3 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Rahman Karimi MD | | | | | 23B. DATE SIGNED 8/3/72 | | | 23C. PHYSICIAN'S NAME (Type) RAHMAN KARIMI MD | |
| 23D. ADDRESS ST AGNES HOSPITAL - WILKENS & CATON AVE | | | | | 23E. FUNERAL DIRECTOR SINGLETON FUNERAL HOME GLEN BURNIE, Md. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 8/7/72 | | 24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | | | 24D. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 7 1972 | | | 25B. NAME OF REGISTRAR Sidney H. Heston | | 25C. FUNERAL DIRECTOR SINGLETON FUNERAL HOME GLEN BURNIE, Md. | | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07474 | |
|--|------------------|---|---|--|---|
| BIRTH NO. 72 07474 | | | | STATE OF MARYLAND-DHMH | |
| 1. NAME OF DECEASED BERNARD EUGENE BENGSTON <i>BERNARD BENGSTON</i> | | | 2. DATE AND HOUR OF DEATH 8/2/1972 5:25 P.M. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 4 "UNION MEMORIAL HOSPITAL" UNION MEMORIAL HOSPITAL | | | A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE MD D. INSIDE CITY LIMITS? 21239 YES <input checked="" type="checkbox"/> No <input type="checkbox"/> E. STREET AND NUMBER 1806 RAMBLEWOOD RD. 2758 | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-23-1893 | 9. AGE (in years last birthday) 79 | 10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist | | | 10B. KIND OF BUSINESS OR INDUSTRY | | |
| 11. BIRTHPLACE (State or foreign country) SWEDEN | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. NATIONAL AMERICAN | | |
| 13. FATHER'S NAME Stephen XXXXXX BENGSTON | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI | | | 16. SOCIAL SECURITY NO. 220-445094 | | |
| 17. INFORMANT Eleanor Bengston, | | | ADDRESS 1806 Ramblewood Rd. Apt B | | |
| 18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RESPIRATORY INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF: BY ASPIRATION | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. AGE, PERIPHERIC ARTERIAL INSUFFICIENCY, CARDIOVASCULAR DIVERSE, ASPIRATIVE PNEUMONIA INTERSTITIAL PNEUMONITIS | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 20 19 72 to August 2 19 72 that (I) (we) lost saw the deceased alive on 8/2/72 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Antonio Santos Martins M.D. | | | | 23B. DATE SIGNED 8/2/1972 | |
| 23C. PHYSICIAN'S NAME (Type) ANTONIO SANTOS MARTINS | | | | 23D. ADDRESS "UNION MEMORIAL HOSPITAL" | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-5-72 | | 24C. NAME OF CEMETERY or CREMATORY Moreland Memorial | |
| 24D. LOCATION Balto., Md. | | 25A. DATE REC'D BY HEALTH DEPT. AUG 7 1972 | | 25B. NAME OF REGISTRAR Anthony [Signature] | |
| 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., | | ADDRESS 5305 Harford Rd. | | | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07475 | |
|---|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 72 07475 | | STATE OF MARYLAND - DEMO | | | |
| 1. NAME OF DECEASED (Type or Print) J. Walter Ende | | 2. DATE AND HOUR OF DEATH 8-2-72 7:30 P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | | | |
| CERTIFICATE AMENDED 37 Mercy Hospital, Inc. 8-14-72 | | Maryland 2632 | | | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 12-21-24 94 | | 9. AGE (in years last birthday) 77 75 | | 10. AGE Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Engineer- Mercy Hosp. Retired | | Retired | | Md | |
| 12. CITIZEN OF WHAT COUNTRY? | | USA | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| Julius Ende | | Marie - | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| Yes - no WW I | | 219-30-9859 | | Mrs. Marie E. Ende same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF | | 10 yrs. | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF | | 1 month | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | Status Post op CARCINOMA of Lung | | 7 yrs | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | yes. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-13 1972 to 8-2 1972 that (I) (we) last saw the deceased alive on 8-2 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Joseph A. Mead Jr MD | | | | 23B. DATE SIGNED 8/3/72 | |
| 23C. PHYSICIAN'S NAME (Type) Joseph A. Mead Jr MD | | | | 23D. ADDRESS 301 St Paul Place, Baltimore Md 21202 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 8/7/72 | | Holy Redeemer | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| AUG 7 1972 | | Frederick M. Weston | | Leonard J. Ruck Inc. Balto. Md. | |

8-14-1972 - Correction form from Funeral Home - Leonard J. Ruck, Inc.
5305 Harford Road, Balto., Md. 21214

HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07476 | | 72 07476 | |
|---|--------------|---|------------------------------|---|-----------------------------|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | STATE OF MARYLAND-DEMD | |
| BIRTH NO. 72 07476 | | 1. NAME OF DECEASED CYRIL SNOWDEN SHARFF | | 2. DATE AND HOUR OF DEATH 8-2-72 9:30 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Union Memorial Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY — | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital | | IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 3633 Greenmount Ave - Apt 203 | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-30-06 | 9. AGE (In years last birthday) 65 | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY B&O R.R. | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Ernest F. Sharff | | 14. MOTHER'S MAIDEN NAME SNOWDEN Catherine | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown | | 16. SOCIAL SECURITY NO. 705034052 | | 17. INFORMANT Charles M. Sharff, ADDRESS Chart 8321 Morven Rd. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 44441 Anterograde pulmonary embolus | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hours | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Anterograde cardiac disease | | | | | | | |
| 19A. DATE OF OPERATION 18-1-72 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Popliteal art. atherosclerosis | | 20A. AUTOPSY (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-2-72 to 8-2-1972 that (I) (we) last saw the deceased alive on 8-2-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Cesar A. Alegre | | | | 23B. DATE SIGNED 8-2-72 | | | |
| 23C. PHYSICIAN'S NAME (Type) CESAR A. ALEGRE | | 23D. ADDRESS Union Memorial Hospital | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-5-72 | | 24C. NAME OF CEMETERY OR CREMATORY Baltimore | | 24D. LOCATION (City, town, or county) (State) Balto., Md. | |
| 25A. DATE RECD BY HEALTH DEPT. AUG 7 1972 | | 25B. NAME OF REGISTRAR 972020 | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., 5305 Harford Rd. | | | |

SHOWN

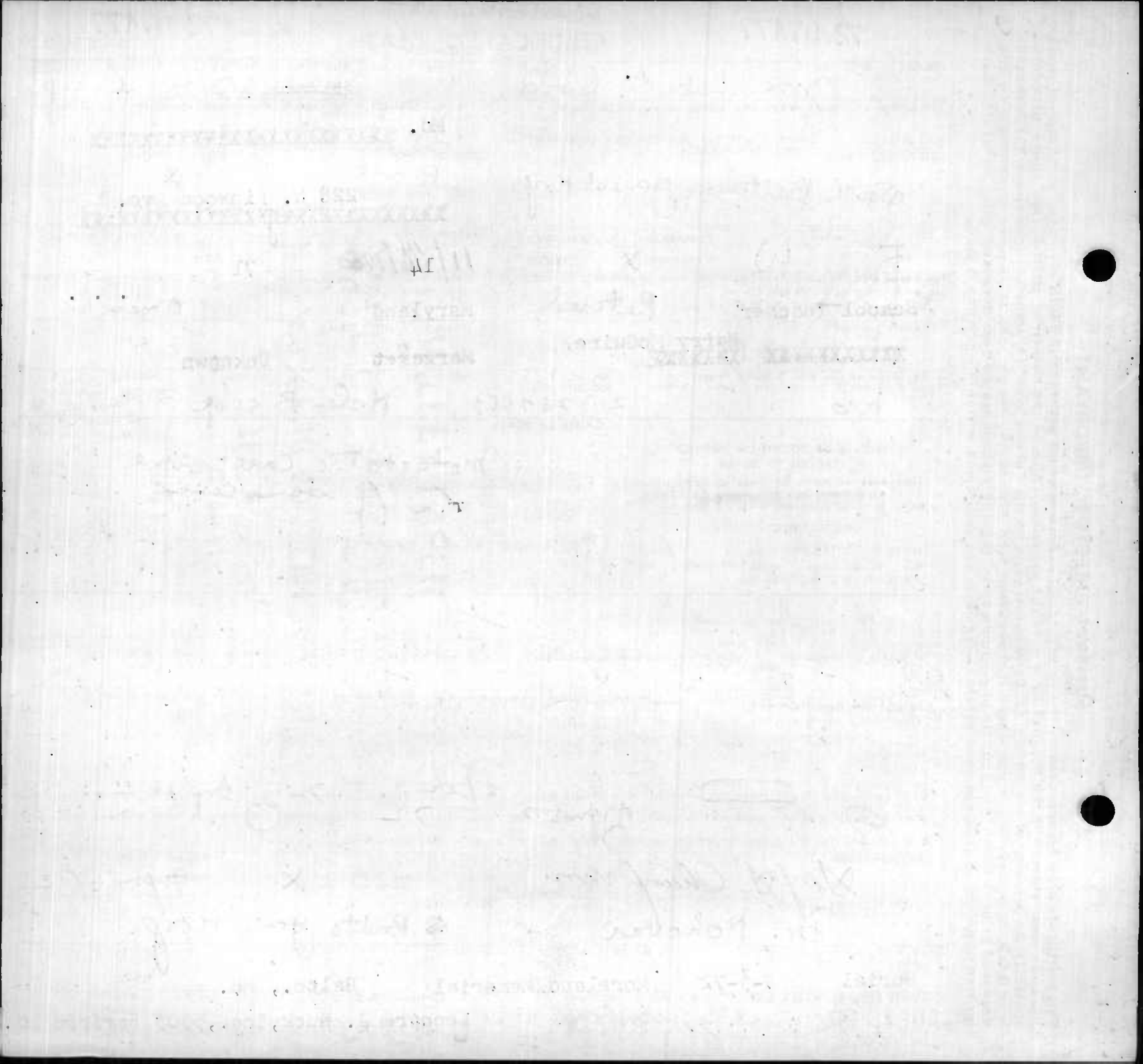
Charles H. Smith

10000000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07477 | |
|--|-----------|---|-----------------------------|---|--|
| 72 07477 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) Mrs. Lula A. Cold | | 2. DATE AND HOUR OF DEATH 8/2/72 4:20 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY Baltimore | | 5. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| FULL NAME OF HOSPITAL OR INSTITUTION 3 South Baltimore General Hosp. | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | E. STREET AND NUMBER 228 N. Linwood Ave. | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/14/1900 | 9. AGE (In years last birthday) 71 | 10. UNDER 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher | | 10B. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTH PLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Harry McGuire | | 14. MOTHER'S MAIDEN NAME Margaret Unknown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213 267 553 | | 17. INFORMANT Helen Biscoe 3838 Rolling Ave. Balto. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 180X I Metastatic Carcinoma of uterine cervix. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II | | 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ✓ | |
| 20A. AUTOPSY? (Yes or No) ✓ | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/22 1972 to August 2 1972 that (I) (we) last saw the deceased alive on August 2 1972 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dr. Honohan | | 23B. DATE SIGNED August 2/72 | | 23C. PHYSICIAN'S NAME (Type) Dr. Honohan | |
| 23D. ADDRESS S. Balto. Gen. Hosp. | | 23E. FUNERAL DIRECTOR Leonard J. Ruck, Inc., 5305 Harford Rd. | | 23F. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-5-72 | | 24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial | |
| 24D. LOCATION Balto., Md. | | 24E. DATE REC'D BY HEALTH DEPT. AUG 7 1972 | | 24F. NAME OF REGISTRAR Sidney H. Heston | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|---|------------------------------------|---|---|
| 72 07478 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07478 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | STATE OF MARYLAND - DEPT | |
| 1. NAME OF DECEASED (Type or Print) CROSSLLEY CARRIE | | 2. DATE AND HOUR OF DEATH Aug 1st 1972 1.30PM M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY HARBOUR VIEW NURSING HOME, BART. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 3 SOUTH BALTIMORE GEN HOSP. | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3001 HANOVER ST. 212 25 | | E. STREET AND NUMBER 1213 LIGHT ST. | | 2636 | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/4/88 | 9. AGE (In years lost birthday) 83 yrs | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10B. KIND OF BUSINESS OR INDUSTRY NONE | | 11. BIRTHPLACE (State or foreign country) Chestertown, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? USA. | | 13. FATHER'S NAME Thomas R. Crossley | | 14. MOTHER'S MAIDEN NAME Eleanor M. Garrett | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 212-07-6865 | | 17. INFORMANT Mrs Ida Biscoe 404 Roanoke Drive | |
| 18. 485X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRONCHIAL PNEUMONIA. | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 16 days | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). DEHYDRATION. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/16/72 19 72 to 8/1/72 19 72 , that (I) (we) last saw the deceased alive on 8/1 1.30PM 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Bo' Keefe MD. | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) BO' KEEFE | | 23D. ADDRESS G. Truman Schwab 5151 Balto. Nat'l. Pike | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/4/1972 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park | |
| 24D. LOCATION Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. AUG 7 1972 | | | |
| 25B. NAME OF REGISTRAR Wm. J. ... | | 25C. FUNERAL DIRECTOR G. Truman Schwab | | | |

4/1/70 - Adm.

1101 Elrino Way 21224

CERTIFICATE OF DEATH

REG. NO.

72 07479

STATE OF MARYLAND-DEME

BIRTH NO.

72 07479

1. NAME OF DECEASED

(Type or Print)

CHURCH, CLAUDE COLBURN

2. DATE AND HOUR OF DEATH

AUGUST 5, 1972

1:50 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)ST AGNES HOSPITAL
CATON & WILKENS AVENUES
BALTIMORE, MARYLAND 21229

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

BALTIMORE

21229

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

BALTIMORE Highlands

YES ☐NO ☒

E. STREET AND NUMBER

2817 NEW YORK AVENUE

5. SEX

MALE

6. RACE

CAUCASIAN

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

07/26/05

9. AGE (In years
last birthday)

67

If Under 1 Yr.

Months: Days

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

BUS DRIVER

10B. KIND OF BUSINESS OR INDUSTRY

TRANSIT

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Christian C. Church

14. MOTHER'S MAIDEN NAME

ELIZABETH SANNER

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

YES

W W 2

16. SOCIAL
SECURITY NO.

213-10-9824

17. INFORMANT

BALTO MD 21229

ADDRESS

ST AGNES' RECORDS CATON & WILKENS AVES

18. 162.1 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).Chronic obstructive lung disease
Gastrointestinal bleeding of unknown etiology

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐
WorkNot While ☐
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that ☒ (this hospital) attended the deceased from JULY 8 1972 to ~~XXXX~~ AUGUST 5 1972.
that ☒ (we) lost saw the deceased alive on AUGUST 5 1972 and that in ~~XXXX~~ (our) opinion death occurred on the date
and hour and from the causes stated above. ☒ (We) (did) ~~XXXX~~ view the body after death.

23A. SIGNATURE

Vincent H. Wang M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

08/05/72

23C. PHYSICIAN'S
NAME (Type)

VINCENT H. WANG, M.D.

23D. ADDRESS

BALTO MD 21229

ST AGNES HOSPITAL CATON & WILKENS AVES

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/8/72

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Singleton Funeral Home, Glen Burnie, Md

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CHARGE, CLARK COUNTY

AUGUST 2, 1972

11:30

NEWLAND, WILLIAM

XX

CLARK COUNTY

2017 NEW YORK AVENUE

BALTIMORE, MARYLAND 21223

XXXX

0726102

CONCEALING

PAID

END DRIVER

WORKING

ELIZABETH CANNED

CHARGE, CLARK COUNTY

BALTO MD 21223

21-11-02 ST AGNES HOSPITAL, CATON & WILKINS AVE

(Signature)

CLARK COUNTY

CLARK COUNTY

CLARK COUNTY

CLARK COUNTY

CLARK COUNTY

CLARK COUNTY

CLARK COUNTY

CLARK COUNTY

CLARK COUNTY

CLARK COUNTY

CLARK COUNTY

CLARK COUNTY

CLARK COUNTY

CLARK COUNTY

CLARK COUNTY

21-11-02

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JULY 1, 1972

AUGUST 2, 1972

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ST AGNES HOSPITAL, CATON & WILKINS AVE

BALTO MD 21223

CLARK COUNTY

CLARK COUNTY

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CLARK COUNTY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | REG. NO. 72 07480 | |
|---|--|--|--|--|--|
| BIRTH NO. 72 07480 | | STATE OF MARYLAND - DEPT. OF HEALTH | | | |
| 1. NAME OF DECEASED (Type or Print) VICTOR E. POGGIE, SR. | | 2. DATE AND HOUR OF DEATH AUGUST 4, 1972 3:25 P. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) #3617 PARKDALE AVENUE | | A. STATE MD. B. COUNTY ANNE ARUNDEL | | | |
| 5. SEX MALE 6. RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH APRIL 24, 1900 9. AGE (In years last birthday) 72 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ASSEMBLYMAN (ret.) | | 10B. KIND OF BUSINESS OR INDUSTRY WESTINGHOUSE | | 11. BIRTHPLACE (State or foreign country) PENNSYLVANIA | |
| 13. FATHER'S NAME DAVID POGGIE | | 14. MOTHER'S MAIDEN NAME ELIZABETH (unknown) | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 212/10/6021 | | 17. INFORMANT ADDRESS Mr. Victor E. Poggie, Jr. (son) Pasadena, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH Myocardial Infarction | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: AS HD | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (B) DUE TO, OR AS A CONSEQUENCE OF: CVA, Peptic Ulcer | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7.28.1972 to 7.29.1972 that (I) (we) last saw the deceased alive on 8.2.1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE C. Dorkan | | 23B. DATE SIGNED 8.4.72 | | 23C. PHYSICIAN'S NAME (Type) C. DORKAN, MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8/8/72 | | 24C. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 7 1972 | | 25B. NAME OF REGISTRAR Sidney W. Heston | | 25C. FUNERAL DIRECTOR GLEN BURNIE | |
| 25D. ADDRESS 325 HOSPITAL DR. Baltimore, Md. | | 25E. ADDRESS 519 Manor Road, Glen Burnie, Md. | | | |

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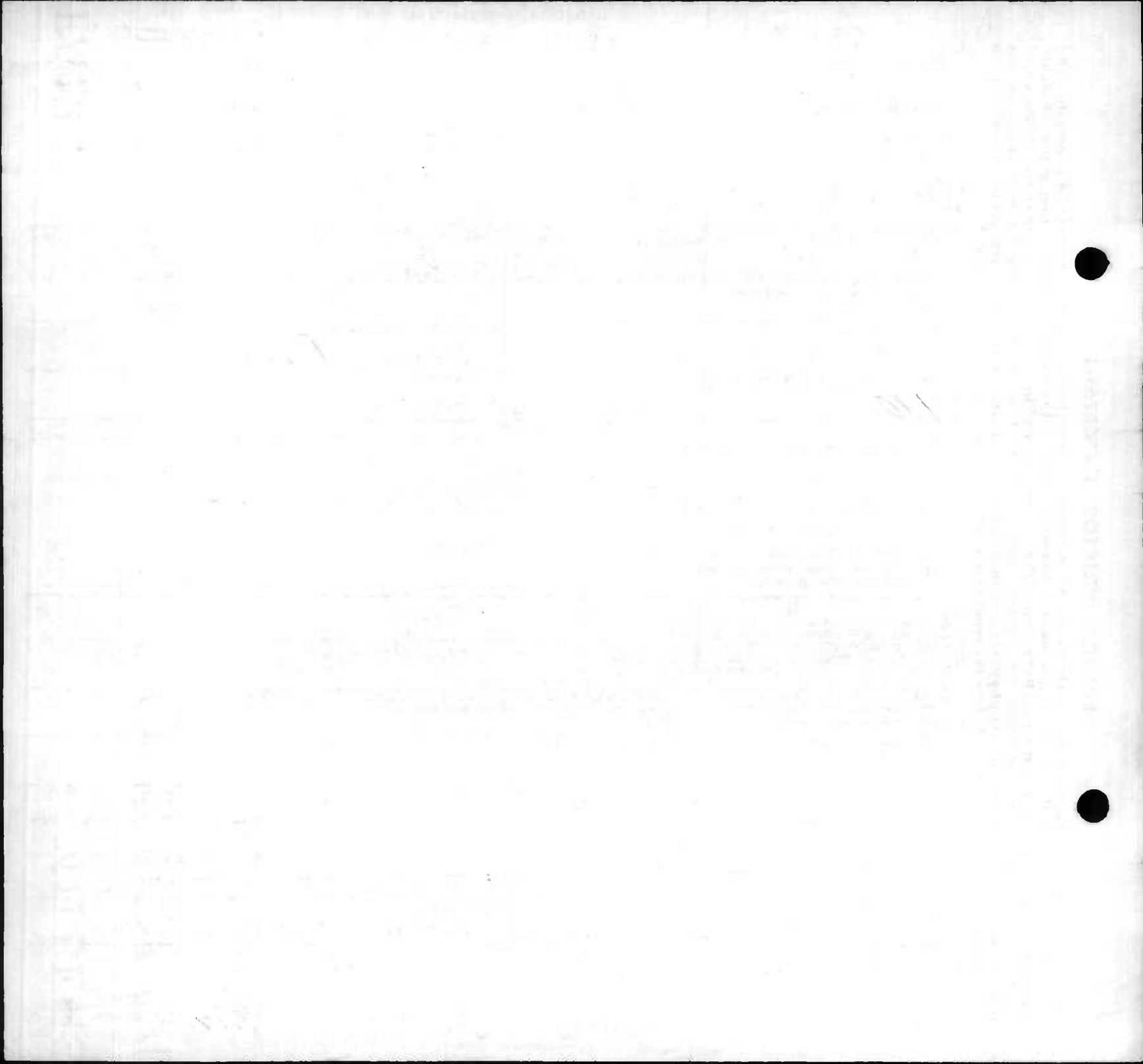
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07481 | |
|--|----------------------------|---|-------------------------------------|---|--|
| 72 07481 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>James F. O'Brien</i> | | 2. DATE AND HOUR OF DEATH <i>8-3-72</i> STATE OF <i>MARYLAND</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1207</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i> | | C. CITY OR TOWN <i>Baltimore</i> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <i>2654 Miles Ave.</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>12-30-05</i> | 9. AGE (In years last birthday) <i>67</i> | 10. Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired.</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>—</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Patrick O'Brien</i> | | 14. MOTHER'S MAIDEN NAME <i>Delores Ryan</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Unknown</i> | | 16. SOCIAL SECURITY NO. <i>214-03-1372</i> | | 17. INFORMANT <i>Chad.</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>55201 x 199.0</i> | | CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Possible pulmonary embolus and septic shock</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <i>—</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Metastatic carcinoma on rectum & anal</i> | | 19A. DATE OF OPERATION <i>7-29-72</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Bleeding duod. ulcer</i> | |
| 20A. AUTOPSY (Yes or No) <i>—</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>7-30-</i> <i>1972</i> to <i>8-3-</i> <i>1972</i> that (I) (we) last saw the deceased alive on <i>8-3-</i> <i>1972</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Cesar A. Auger</i> | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>8-3-72</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>CESAR A. AUGER</i> | | 23D. ADDRESS <i>Union Memorial Hosp.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | 24B. DATE <i>8/7/72</i> | 24C. NAME OF CEMETERY OR CREMATORY <i>ST. MARY'S</i> | | 24D. LOCATION (City, town, or county) (State) <i>BALTO. MD.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>AUG 7 1972</i> | | 25B. NAME OF REGISTRAR <i>Arline Johnson</i> | | 25C. FUNERAL DIRECTOR <i>Paul E. Chenoweth</i> | |
| | | | | ADDRESS <i>3617 Chestnut Ave.</i> | |



35-78-00 sj
W-42

72 07482

BALTIMORE CITY HEALTH DEPARTMENT

72 07482

CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Lula

huhu

Wilson

Wilson

2. DATE AND HOUR OF DEATH

July 27, 1972

5:30

STATE OF MARYLAND-DEPT. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

4940 Eastern Avenue

Baltimore, Maryland

21224

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

4940 Eastern Avenue

21224

5. SEX

Female

6. RACE

Negro

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

5-10-99

9. AGE (In years last birthday)

73

11. Under 1 Yr. Months: Days:

12. Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Promise Gilmore

14. MOTHER'S MAIDEN NAME

Estelle

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

220-30-2215

17. INFORMANT

4940 Eastern Avenue

BCH- Baltimore, Maryland 21224

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(C) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Peter J. Dorsen M.D.

DEGREE

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

7/26

23C. PHYSICIAN'S NAME (Type)

Peter Dorsen M.D.

DEGREE

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Maryland 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-5-72

24C. NAME OF CEMETERY OR CREMATORY

Mt Calvary Cemetery

24D. LOCATION (City, town, or county)

Anne Arundel Cty., Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 7 1972

25B. NAME OF REGISTRAR

Sidney H. Hinton

25C. FUNERAL DIRECTOR

Wm J. March

ADDRESS

928 E North Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

8/20/62 - Adm.

Wilson

Miss

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N.C.

Hastelle

Promiss Gilmore

220-30-2212

Anne Arundel Cty., Md.

Mt Calvary Cemetery

8-2-72

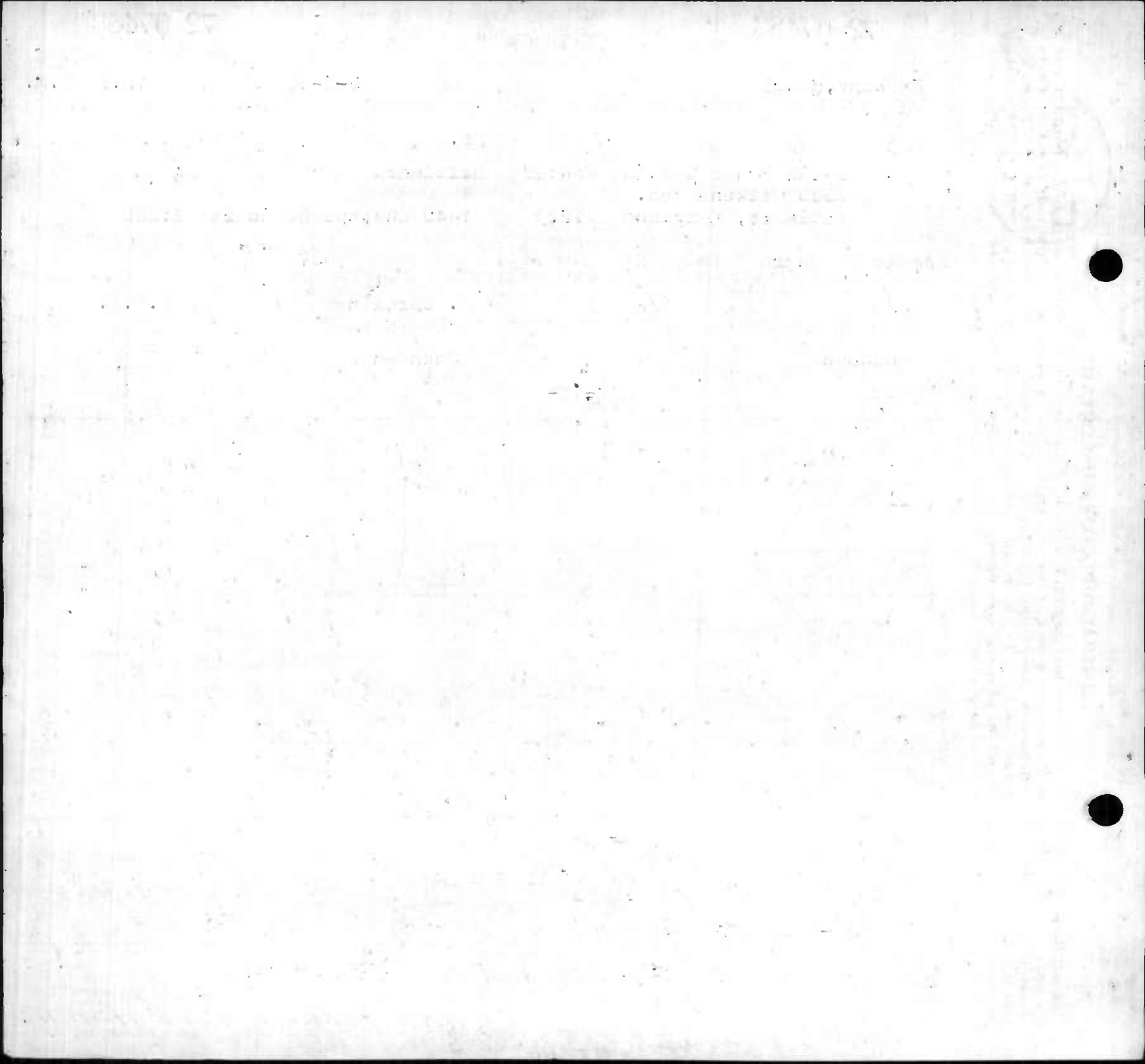
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Wm C March 928 E North Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07483 | |
|---|--|--|---|--|--|
| 72 07483 | | | | STATE OF MARYLAND - DUMM | |
| BIRTH NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Hawkins, Cora | | | 8-2-72 10:50 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 90 Caton Manor Nursing Center 3330 Wilkens Ave. Baltimore, Maryland 21229 | | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 5. SEX Female 6. RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH 9. AGE (In years last birthday) 87 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A | | | 11. BIRTHPLACE (State or foreign country) N. Carolina | | |
| 10B. KIND OF BUSINESS OR INDUSTRY N/A | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Unknown | | | 14. MOTHER'S MAIDEN NAME Unknown | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) N/A | | | 16. SOCIAL SECURITY NO. 3839 | | |
| 17. INFORMANT | | | ADDRESS | | |
| 18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Cerebral Clot DUE TO, OR AS A CONSEQUENCE OF: (B) metastases DUE TO, OR AS A CONSEQUENCE OF: (C) 6th | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 17 1972 to Aug 2 1972 , that (I) last saw the deceased alive on July 27 1972 and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Nelson McKay MD | | | | 23B. DATE SIGNED Aug 4, 1972 | |
| 23C. PHYSICIAN'S NAME (Type) NELSON MCKAY MD | | | | 23D. ADDRESS 1132 Rolling Rd 21228 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-5-72 | | 24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cem | |
| 24D. LOCATION (City, town, or county) Balto Md. | | 24E. LOCATION (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 7 1972 | | 25B. NAME OF REGISTRAR Sidney | | 25C. FUNERAL DIRECTOR WM C ARCH ADDRESS 928 E North Ave | |



19-624

72 07484

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07484

BIRTH NO.

REG. NO.

1. NAME OF DECEASED
(Type or Print)

ERNEST MARSHALL JR.

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

1606

6. SEX

male

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

12-1-50

10. AGE (In years
last birthday)

21

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3052 Aroun Ave.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Ernest Marshall Sr

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Lillian M. Hunter

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Ernest Marshall Sr. 2308 Winchester St

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Gunshot wound of head and chest

(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

street

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?
558 Wilson St.22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.) 8-3-72 1:30 a m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot by unknown assailant.

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Marvin S. Platt, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-3-72

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8-7-72

24C. NAME of CEMETERY or CREMATORY

Gardens of Eternal Hope Westminster, Md.

24D. LOCATION (City, town, or county)

(State)

25A. DATE RECEIVED BY HEALTH DEPT.

AUG 7 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Wm C March 928 E North Ave.

72-175

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C.

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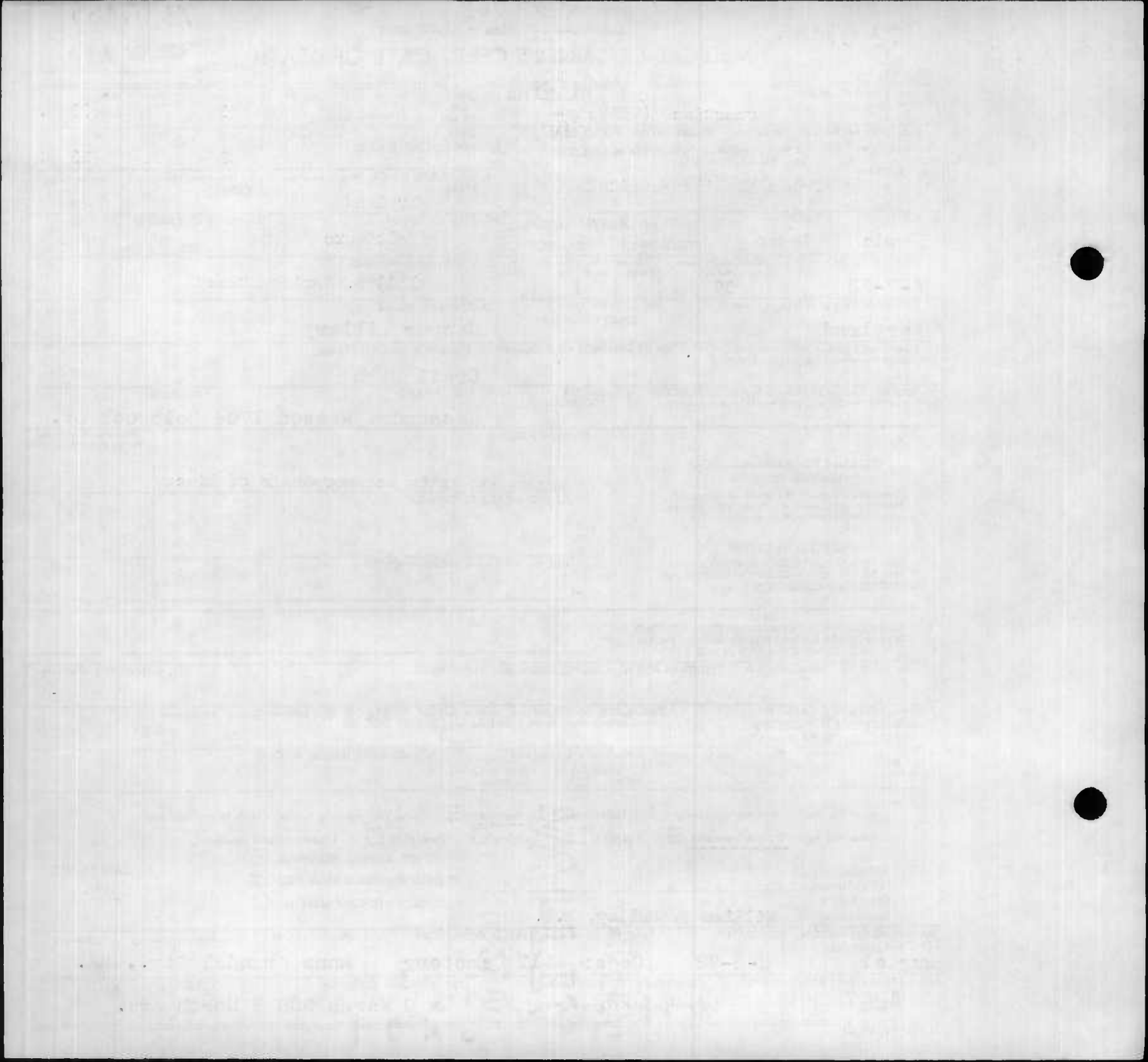
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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

STATE OF MARYLAND-DH
NO. _____

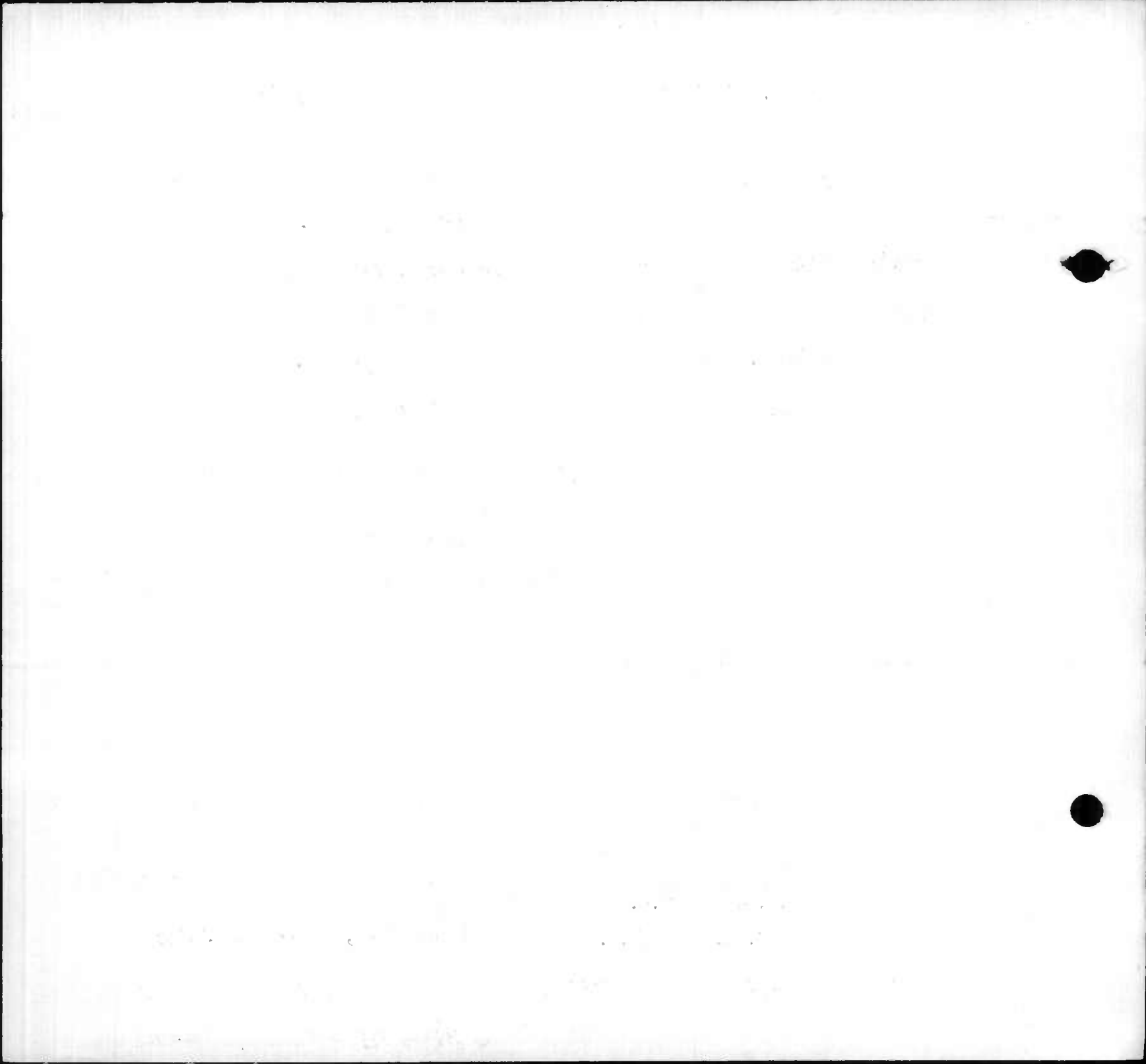
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|--|--|---|--|
| BIRTH NO. | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE OF DEATH | |
| Ernestine (Wilkins) | | Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 3. DATE PRONOUNCED DEAD | |
| 33 Johns Hopkins Hospital | | Month 8 Day 3 Year 72 Hour 9:33 P. | |
| 6. SEX Female | | 7. RACE Negro | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. DATE OF BIRTH 5-7-33 | |
| 10. AGE (In years last birthday) 39 | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME Jasper Tillery | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 15. MOTHER'S MAIDEN NAME Cecil High | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT Cassandra Watson | | 19. ADDRESS 1706 Holbrook St. | |
| 20. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | 21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 22. DATE OF OPERATION | | 23. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 24. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 26. TIME OF INJURY (APPROX.) | | 27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 28. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 29. HOW DID INJURY OCCUR? | |
| 30. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 31. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| 32. ACTUAL SIGNATURE William P. Mulloy, M.D. | | 33. DATE SIGNED 8-4-72 | |
| 34. BURIAL CREMATION, REMOVAL (Specify) Burial | | 35. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery | |
| 36. DATE 8-8-72 | | 37. LOCATION (City, town, or county) (State) Anne Arundel Cty., Md. | |
| 38. DATE REC'D BY HEALTH DEPT. AUG 7 1972 | | 39. NAME OF REGISTRAR Sidney J. Weston | |
| 40. FUNERAL DIRECTOR Wm C March | | 41. ADDRESS 928 E North Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07486 | | REG. NO. 72 07486 | |
|--|-------------------------|---|--|---|--|---|--|
| BIRTH NO. 72 07486 | | | | CERTIFICATE OF DEATH | | | |
| STATE OF MARYLAND - DEPT. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Eva E. Wilkinson</u> | | | | August 2, 1972 3 A M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 1008 Woodson Road</u> | | | | A. STATE <u>Maryland</u> B. COUNTY <u>2768</u> | | | |
| | | | | C. CITY OR TOWN <u>Baltimore</u> | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER <u>1008 Woodson Road</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>October 3, 1881</u> | 9. AGE (In years last birthday) <u>90</u> | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>homemaker</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Daniel S. Jones</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sarah C. Roberts</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no none</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Family records</u> | | ADDRESS | |
| 18. I <u>438791</u> CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Bronchopneumonia</u> | | | | <u>3-4 days</u> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (B) <u>Hemiplegia</u> DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (C) <u>Arteriosclerosis</u> <u>15 years</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>July 1972</u> to <u>Aug. 1, 1972</u> that (I) <u>we</u> last saw the deceased alive on <u>Aug 1</u> 1972 and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>K. A. Manley, M.D.</u> | | | | 23B. DATE SIGNED <u>8.3.72</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>K. A. MANLEY, M.D.</u> | | | | 23D. ADDRESS <u>2045 York Road, Timonium, Md. 21093</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>8-5-72</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Cedar Hill Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 7 1972</u> | | 25B. NAME OF REGISTRAR <u>John Burdett</u> | | 25C. FUNERAL DIRECTOR <u>John Burdett</u> | | ADDRESS <u>Towson</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 72 07487 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07487 | | STATE OF MARYLAND-DMH | |
|--|-------------------------|---|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Picariello Vincent, L. | | | | 2. DATE AND HOUR OF DEATH 8/4/72 8-15 P.M. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY U.S.A. | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL | | | | C. CITY OR TOWN Baltimore | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 | | | | E. STREET AND NUMBER 3813 Walnut AVE, BALTI, Md 21206 | | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 03-24-12 | 9. AGE (In years last birthday) 60 years | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | | 10B. KIND OF BUSINESS OR INDUSTRY General Motors | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME CARMINE PICARIELLO | | | | 14. MOTHER'S MAIDEN NAME CONSTANCE SPINA | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown | | | | 16. SOCIAL SECURITY NO. 216-01-5000 | | 17. INFORMANT Charles | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cardiovascular collapse | | | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebrovascular accident with | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. uncontrolled diabetes mellitus | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: a long standing | | | | | |
| (C) diagnosis | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that N (this hospital) attended the deceased from 07/24 19 72 to 8/4 19 72 , that N (we) last saw the deceased alive on 8/4 19 72 and that ln (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE H. Shocair | | | | MD Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 8/4/72 | | | |
| 23C. PHYSICIAN'S NAME (Type) MAWYA SHOCAIR MD | | | | 23D. ADDRESS Union Memorial Hospital Baltimore Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE AUG 8-72 | | 24C. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEM | | 24D. LOCATION (City, town, or county) (State) 4470 BELAIR RD BALTO MD | | | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 7 1972 | | 25B. NAME OF REGISTRAR Frederick H. Brown | | 25C. FUNERAL DIRECTOR DIPPEL BROS INC 7110 BELAIR RD | | | | | |

Aug 8-12 Hwy 101/102/103/104/105/106/107/108/109/110/111/112/113/114/115/116/117/118/119/120/121/122/123/124/125/126/127/128/129/130/131/132/133/134/135/136/137/138/139/140/141/142/143/144/145/146/147/148/149/150/151/152/153/154/155/156/157/158/159/160/161/162/163/164/165/166/167/168/169/170/171/172/173/174/175/176/177/178/179/180/181/182/183/184/185/186/187/188/189/190/191/192/193/194/195/196/197/198/199/200/201/202/203/204/205/206/207/208/209/210/211/212/213/214/215/216/217/218/219/220/221/222/223/224/225/226/227/228/229/230/231/232/233/234/235/236/237/238/239/240/241/242/243/244/245/246/247/248/249/250/251/252/253/254/255/256/257/258/259/260/261/262/263/264/265/266/267/268/269/270/271/272/273/274/275/276/277/278/279/280/281/282/283/284/285/286/287/288/289/290/291/292/293/294/295/296/297/298/299/300/301/302/303/304/305/306/307/308/309/310/311/312/313/314/315/316/317/318/319/320/321/322/323/324/325/326/327/328/329/330/331/332/333/334/335/336/337/338/339/340/341/342/343/344/345/346/347/348/349/350/351/352/353/354/355/356/357/358/359/360/361/362/363/364/365/366/367/368/369/370/371/372/373/374/375/376/377/378/379/380/381/382/383/384/385/386/387/388/389/390/391/392/393/394/395/396/397/398/399/400/401/402/403/404/405/406/407/408/409/410/411/412/413/414/415/416/417/418/419/420/421/422/423/424/425/426/427/428/429/430/431/432/433/434/435/436/437/438/439/440/441/442/443/444/445/446/447/448/449/450/451/452/453/454/455/456/457/458/459/460/461/462/463/464/465/466/467/468/469/470/471/472/473/474/475/476/477/478/479/480/481/482/483/484/485/486/487/488/489/490/491/492/493/494/495/496/497/498/499/500/501/502/503/504/505/506/507/508/509/510/511/512/513/514/515/516/517/518/519/520/521/522/523/524/525/526/527/528/529/530/531/532/533/534/535/536/537/538/539/540/541/542/543/544/545/546/547/548/549/550/551/552/553/554/555/556/557/558/559/560/561/562/563/564/565/566/567/568/569/570/571/572/573/574/575/576/577/578/579/580/581/582/583/584/585/586/587/588/589/590/591/592/593/594/595/596/597/598/599/600/601/602/603/604/605/606/607/608/609/610/611/612/613/614/615/616/617/618/619/620/621/622/623/624/625/626/627/628/629/630/631/632/633/634/635/636/637/638/639/640/641/642/643/644/645/646/647/648/649/650/651/652/653/654/655/656/657/658/659/660/661/662/663/664/665/666/667/668/669/670/671/672/673/674/675/676/677/678/679/680/681/682/683/684/685/686/687/688/689/690/691/692/693/694/695/696/697/698/699/700/701/702/703/704/705/706/707/708/709/710/711/712/713/714/715/716/717/718/719/720/721/722/723/724/725/726/727/728/729/730/731/732/733/734/735/736/737/738/739/740/741/742/743/744/745/746/747/748/749/750/751/752/753/754/755/756/757/758/759/760/761/762/763/764/765/766/767/768/769/770/771/772/773/774/775/776/777/778/779/780/781/782/783/784/785/786/787/788/789/790/791/792/793/794/795/796/797/798/799/800/801/802/803/804/805/806/807/808/809/810/811/812/813/814/815/816/817/818/819/820/821/822/823/824/825/826/827/828/829/830/831/832/833/834/835/836/837/838/839/840/841/842/843/844/845/846/847/848/849/850/851/852/853/854/855/856/857/858/859/860/861/862/863/864/865/866/867/868/869/870/871/872/873/874/875/876/877/878/879/880/881/882/883/884/885/886/887/888/889/890/891/892/893/894/895/896/897/898/899/900/901/902/903/904/905/906/907/908/909/910/911/912/913/914/915/916/917/918/919/920/921/922/923/924/925/926/927/928/929/930/931/932/933/934/935/936/937/938/939/940/941/942/943/944/945/946/947/948/949/950/951/952/953/954/955/956/957/958/959/960/961/962/963/964/965/966/967/968/969/970/971/972/973/974/975/976/977/978/979/980/981/982/983/984/985/986/987/988/989/990/991/992/993/994/995/996/997/998/999/1000/1001/1002/1003/1004/1005/1006/1007/1008/1009/1010/1011/1012/1013/1014/1015/1016/1017/1018/1019/1020/1021/1022/1023/1024/1025/1026/1027/1028/1029/1030/1031/1032/1033/1034/1035/1036/1037/1038/1039/1040/1041/1042/1043/1044/1045/1046/1047/1048/1049/1050/1051/1052/1053/1054/1055/1056/1057/1058/1059/1060/1061/1062/1063/1064/1065/1066/1067/1068/1069/1070/1071/1072/1073/1074/1075/1076/1077/1078/1079/1080/1081/1082/1083/1084/1085/1086/1087/1088/1089/1090/1091/1092/1093/1094/1095/1096/1097/

S-536

72 07488 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

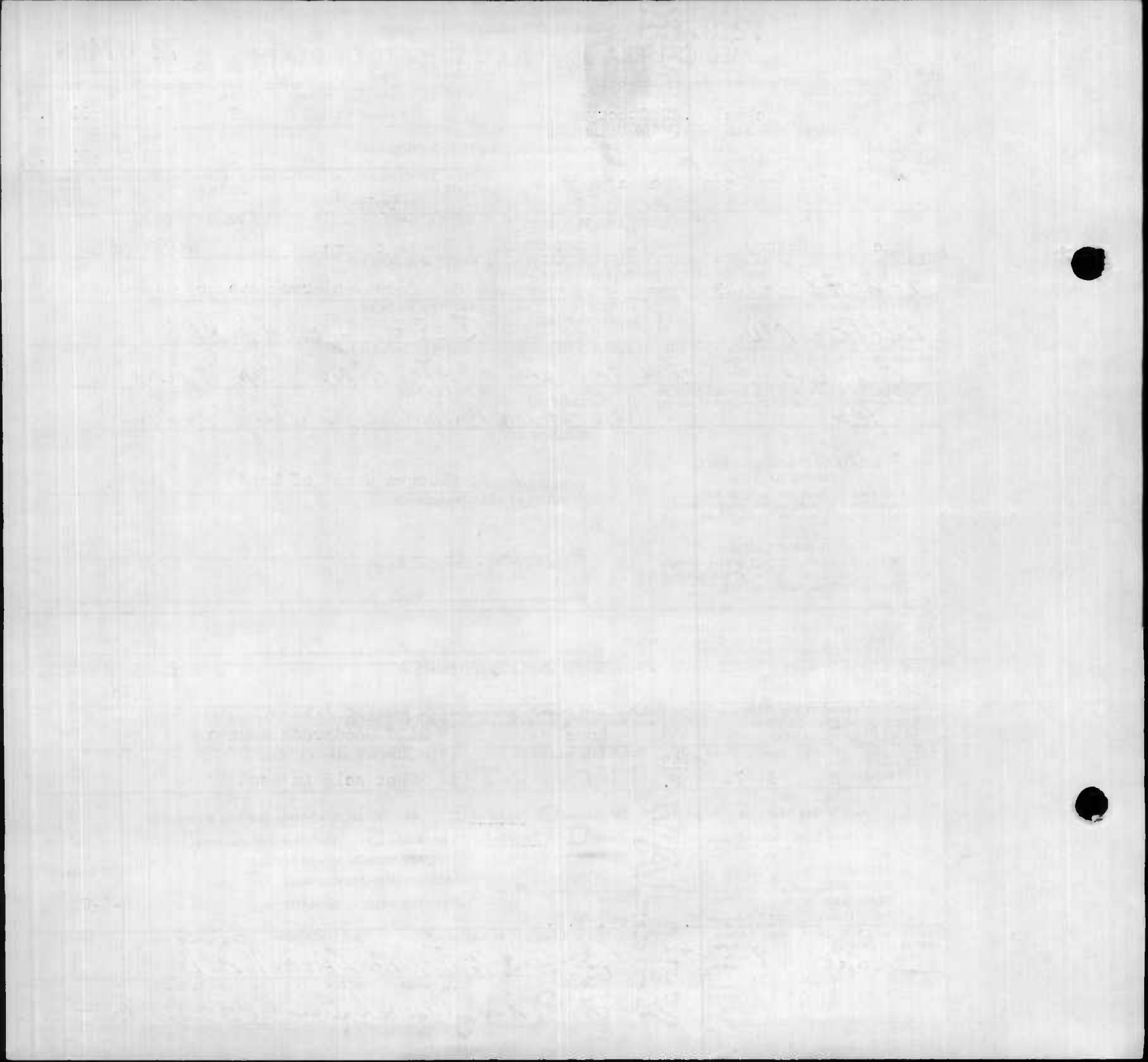
72 07488

BIRTH NO.

STATE OF MARYLAND-DEPT

REG. NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Michael G. Smithery | | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 8 3 72 9:33 P.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2429 Woodbrook Avenue | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 8 3 72 9:33 P.M. | |
| 6. SEX Male | | 7. RACE Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1303 | |
| 9. DATE OF BIRTH 9-6-49 | | 10. AGE (In years lost birthday) 23 11 | |
| 11. BIRTHPLACE (State or foreign country) BALTO. MD. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Jeff Smithery | | 14. MOTHER'S MAIDEN NAME Catherine Smithery | |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CITY WORKER | | 16. KIND OF BUSINESS OR INDUSTRY SANITATION | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, near unknown) (If yes, give war or dates of service) yes | | 18. SOCIAL SECURITY NO. 216-54-2846 | |
| 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | 19. CAUSE OF DEATH (A) IMMEDIATE CAUSE Shotgun Wound of head DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2429 Woodbrook Avenue 1303 | | 22D. TIME OF INJURY (Approx.) 8 3 72 9:33 P.M. | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Shot self in head | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE William P. Mulloy, M.D. EXAMINER'S NAME (Type) 24. BURIAL CREMATION, REMOVAL? (Specify) Burial 24B. DATE 8-8-72 24C. NAME OF CEMETERY or CREMATORY MARYLAND NAT. PARK LAUREL MD. 24D. LOCATION (City, town, or county) (State) 25A. DATE REC'D BY HEALTH DEPT. AUG 7 1972 25B. NAME OF REGISTRAR Sidney H. Weston 25C. FUNERAL DIRECTOR Joseph H. Rues ADDRESS 2222 W. North Ave | | | |



W-656 1

72 07489

BALTIMORE CITY HEALTH DEPARTMENT

72 07489

REG. NO.

STATE OF MARYLAND - DEATH

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ADDIE WARNER

2. DATE AND HOUR OF DEATH

8/8/72

1:15 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

BALTIMORE

B. COUNTY

1801

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

17 N. AMITY ST.

5. SEX

FEMALE

6. RACE

BLACK

7. MARRIED

NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

UNKNOWN 11/19/01

9. AGE (in years last birthday)

UNKNOWN 70

10. Under 1 Yr.

Months: Days: Hours: Min.

11. Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSE WIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

UNKNOWN

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

UNKNOWN

16. SOCIAL SECURITY NO.

17. INFORMANT

Chart

ADDRESS

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause 1A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

TUBERCULOSIS

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

UNKNOWN

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

No

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work

☐

Not While At Work

☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/28 19 72 to 8/4 19 72 that (I) (we) last saw the deceased alive on 8/4 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.

23A. SIGNATURE

Paul D. Light M.D.

DEGREE

Attending Phys.

Med. Director

Staff Phys.

23B. DATE SIGNED

8/4/72

23C. PHYSICIAN'S NAME (Type)

PAUL D. LIGHT M.D.

DEGREE

23D. ADDRESS

UNIVERSITY HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/8/72

24C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 7 1972

25B. NAME OF REGISTRAR

Sidney W. ...

25C. FUNERAL DIRECTOR

3 Adolphus Halstead 1206 W North Ave

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

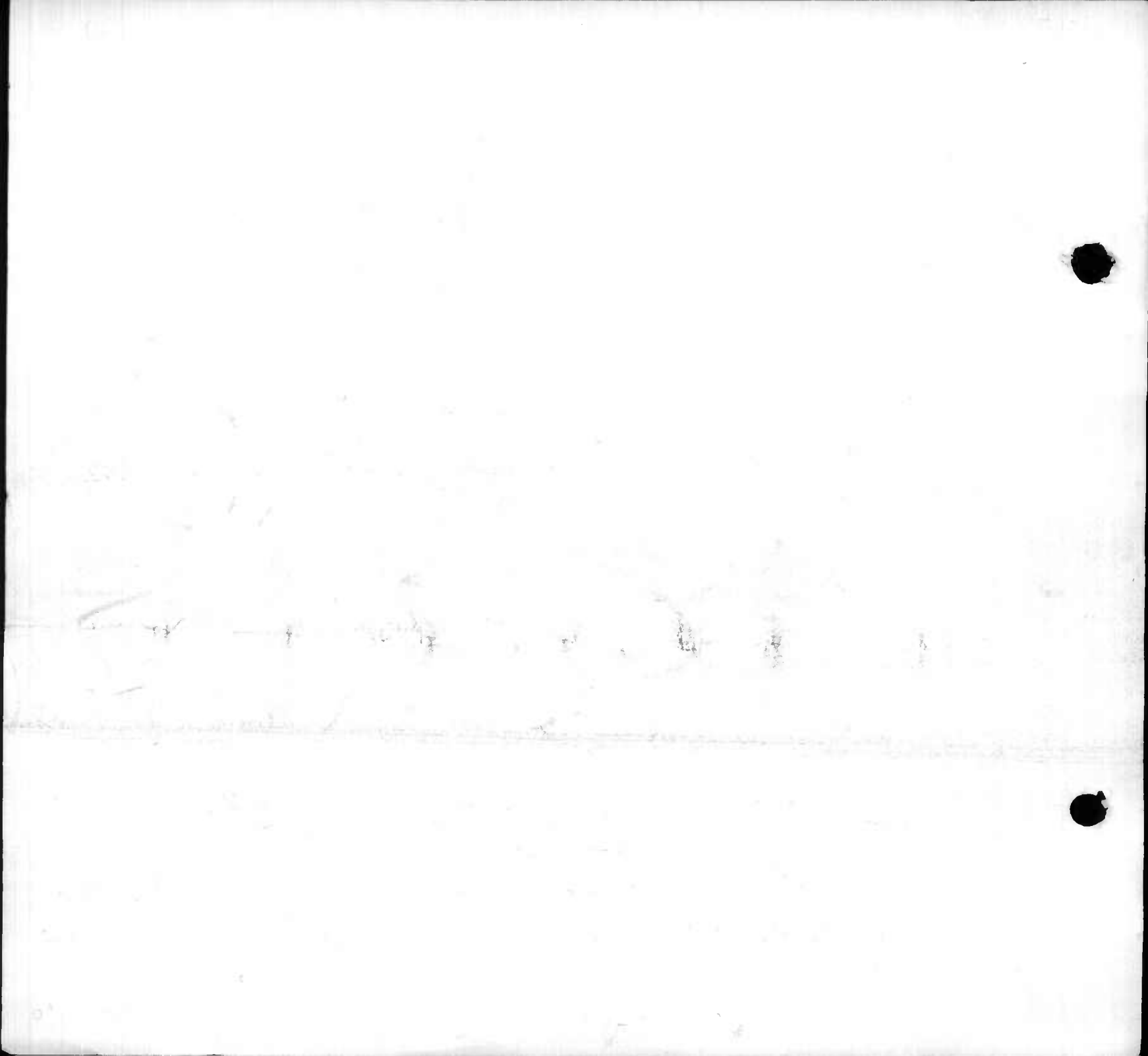
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

date of Birth obtained
for Bureau of Tuberculosis.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|---|--|
| 72 07490 | | BALTIMORE CITY HEALTH DEPARTMENT | | 72 07490 | |
| BIRTH NO. | | 72 07490 | | REG. NO. | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | |
| John Buford Brown | | 8/4/72 12:45 P.M. | | 3. PROVIDENT HOSP | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | 5. CITY OR TOWN | | 6. INSIDE CITY LIMITS? | |
| MARYLAND | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 7. STREET AND NUMBER | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | |
| 2913 Forest Glen Rd | | 3/27/98 | | 73 | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Retired | | Maryland | | USA | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | |
| ?? | | ?? | | 16. SOCIAL SECURITY NO. | |
| | | | | 220-05-32264 | |
| 17. INFORMANT | | 18. CAUSE OF DEATH | | 19. MEDICAL CERTIFICATION | |
| Hospital Records | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | 20. DATE OF OPERATION | |
| | | Bronchogenic Carcinoma | | 21. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | (A) IMMEDIATE CAUSE | | 22. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | |
| | | DUE TO, OR AS A CONSEQUENCE OF: | | 23. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | 24. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | 25. HOW DID INJURY OCCUR? | |
| | | | | 26. TIME OF INJURY (Approx.) | |
| | | | | 27. INJURY OCCURRED | |
| | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| | | | | 28. I certify that (1) (this hospital) attended the deceased from July 19 69 to 8/4 19 72 | |
| | | | | that (1) (we) lost the deceased alive on 7/23/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did not) view the body after death. | |
| 29. SIGNATURE | | 30. DATE SIGNED | | 31. PHYSICIAN'S NAME (Type) | |
| A. C. ALVIZATO, M.D. | | 8/4/72 | | A. C. ALVIZATO, M.D. | |
| 32. ADDRESS | | 33. NAME OF CEMETERY or CREMATORY | | 34. LOCATION (City, town, or county) (State) | |
| 1208 St. Paul St. 21202 | | Mt Auburn Cemetery | | Baltimore, M. | |
| 35. DATE REC'D BY HEALTH DEPT. | | 36. NAME OF REGISTRAR | | 37. FUNERAL DIRECTOR | |
| AUG 7 1972 | | Adolph Halstead | | Adolph Halstead 1206 W North Ave | |



M-6261

72 07491

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

72 07491

CERTIFICATE OF DEATH

STATE OF MARYLAND - DHMH

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

CHARLESE Mercer Sr.

2. DATE AND HOUR OF DEATH

8-5-72

6:35 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BON SECOURS HOSPITAL

34

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

Md. BALT. city

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

845 HARLEM AVE.

5. SEX

M

6. RACE

B

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

8. DATE OF BIRTH

03/19/16

9. AGE (in years
last birthday)

56

11 Under 1 Yr.

Months Days

11 Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

TRUCK DRIVER

10B. KIND OF BUSINESS OR INDUSTRY

CONSOLIDATED
DELIVERIES

11. BIRTHPLACE (State or foreign country)

Md. BALTO

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Basil Mercer

14. MOTHER'S MAIDEN NAME

Emma Jackson

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give year or dates of service)

UNKNOWN

MA

16. SOCIAL
SECURITY NO.

213-01-2587

17. INFORMANT

DEANAC Mercer - 1618-1100
Patient's chart

18.

I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Carcinoma of right main
bronchus with metastases to hilar
lymph nodes and adrenals

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

months

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Polypoid of sigmoid colon

1 day

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7-27-72 to Aug 5 1972

that (I) (we) last saw the deceased alive on Aug 5 1972 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Felimon A. Soria MD

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

8-5-72

23C. PHYSICIAN'S
NAME (Type)

FELIMON A. SORIA M.D.

23D. ADDRESS

BON SECOURS Hospital

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8-9-72

24C. NAME OF CEMETERY OR CREMATORY

Abraham Mem Pk

24D. LOCATION

BALTO, MD

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 7 1972

25B. NAME OF REGISTRAR

John W. Weston

25C. FUNERAL DIRECTOR

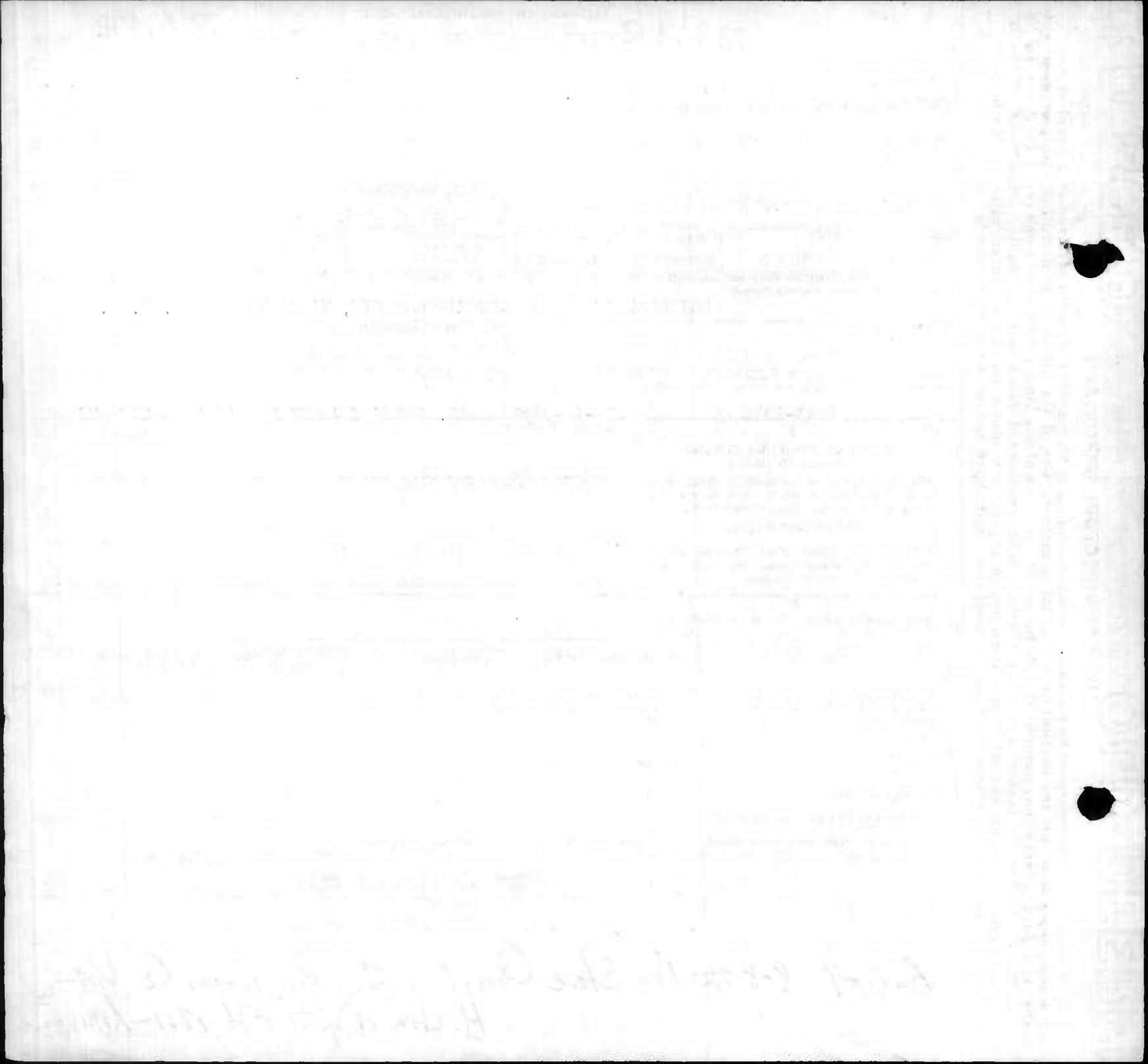
John W. Weston

ADDRESS

1701-1701 St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07493 **CERTIFICATE OF DEATH** 72 07493

REG. NO. **72 07493**
STATE OF MARYLAND-DEMH

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) **WALTER COOK** 2. DATE AND HOUR OF DEATH **8/5/72 12:30 P.M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD _____ 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **MARYLAND** B. COUNTY **1506**

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) **Maryland General Hospital** C. CITY OR TOWN **BALTIMORE** D. INSIDE CITY LIMITS? YES ☒ NO ☐
807 Linden Ave E. STREET AND NUMBER **1506 Broadbush Ave**

5. SEX **M** 6. RACE **N** 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH **12/2/03** 9. AGE (In years last birthday) **68** 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Ret'd** 11. BIRTHPLACE (State or foreign country) **VIRGINIA** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **ALEXANDER COOK** 14. MOTHER'S MAIDEN NAME **Folly Cook**

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) **NA** 16. SOCIAL SECURITY NO. **217-03-9884** 17. INFORMANT **CHARLTON Alexander Cook** ADDRESS **Cliffwood**

18. **530.01** CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH **1/2 hr**

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE **144 POXIA**

ANTECEDENT CAUSES (B) DUE TO, OR AS A CONSEQUENCE OF: **HEMORRAGE, PULMONARY 1 hr**

(C) **ASPIRATION**

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). **ACTUAL ASIA**

19A. DATE OF OPERATION _____ 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No) _____ 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) _____ 21C. WHERE DID INJURY OCCUR? _____ (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR? _____

22. I certify that (I) (this hospital) attended the deceased from **7/17** 19 **72** to **8/5** 19 **72** that (I) (we) last saw the deceased alive on **8/5** 19 **72** and that (a) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE **Chelbrehe** 23B. DATE SIGNED **8/5/72**

23C. PHYSICIAN'S NAME (Type) **AR WILKE** 23D. ADDRESS **3506 CALVERT ST**

24A. BURIAL CREMATION REMOVAL (Specify) **Burial** 24B. DATE **8-9-72** 24C. NAME OF CEMETERY OR CREMATORY **Arbutus Memorial Park** 24D. LOCATION (City, town, or county) (State) **Baltimore, Md**

25A. DATE REC'D BY HEALTH DEPT. **AUG 7 1972** 25B. NAME OF REGISTRAR **Anthony Whitson** 25C. FUNERAL DIRECTOR **1701-havenus** ADDRESS **St**

100-309,271-1978

100-309,271-1978

100-309,271-1978

100-309,271-1978

72 07494

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

72 07494

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SMITH, LEROY JR.

2. DATE AND HOUR OF DEATH

8/4/72

7:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

31

Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

1606

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

637 Rosedale Street 21216

5. SEX

Male

6. RACE

Negro

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

5-30-13

9. AGE (In years
last birthday)

59

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

UNEMPLOYED

11. BIRTHPLACE (State or foreign country)

NEW PORT NEWS, VIRGINIA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WILLIAM SMITH

14. MOTHER'S MAIDEN NAME

VICTORIA SMITH

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

717-09-0433

17. INFORMANT

ADDRESS

BCH Records 4940 Eastern Ave. 21224

18. 1621 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

PNEUMONIA

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B)

CARCINOMA OF LUNGS

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from

8/1/1972 to

8/4/1972

that (I) (we) last saw the deceased alive on

8/4/1972

and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Stanley Zoyac MD

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

8/4/72

23C. PHYSICIAN'S
NAME (Type)

Stanley Zoyac Jr. M.D.

23D. ADDRESS

4940 Eastern Avenue
Baltimore City Hospitals Balto. Md. 21224

DEGREE

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

8-9-72

24C. NAME OF CEMETERY or CREMATORY

MOUNT AUBURN CEMETERY

24D. LOCATION

(City, town, or county)

BALTIMORE, MARYLAND

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 7 1972

25B. NAME OF REGISTRAR

Audrey M. Horton

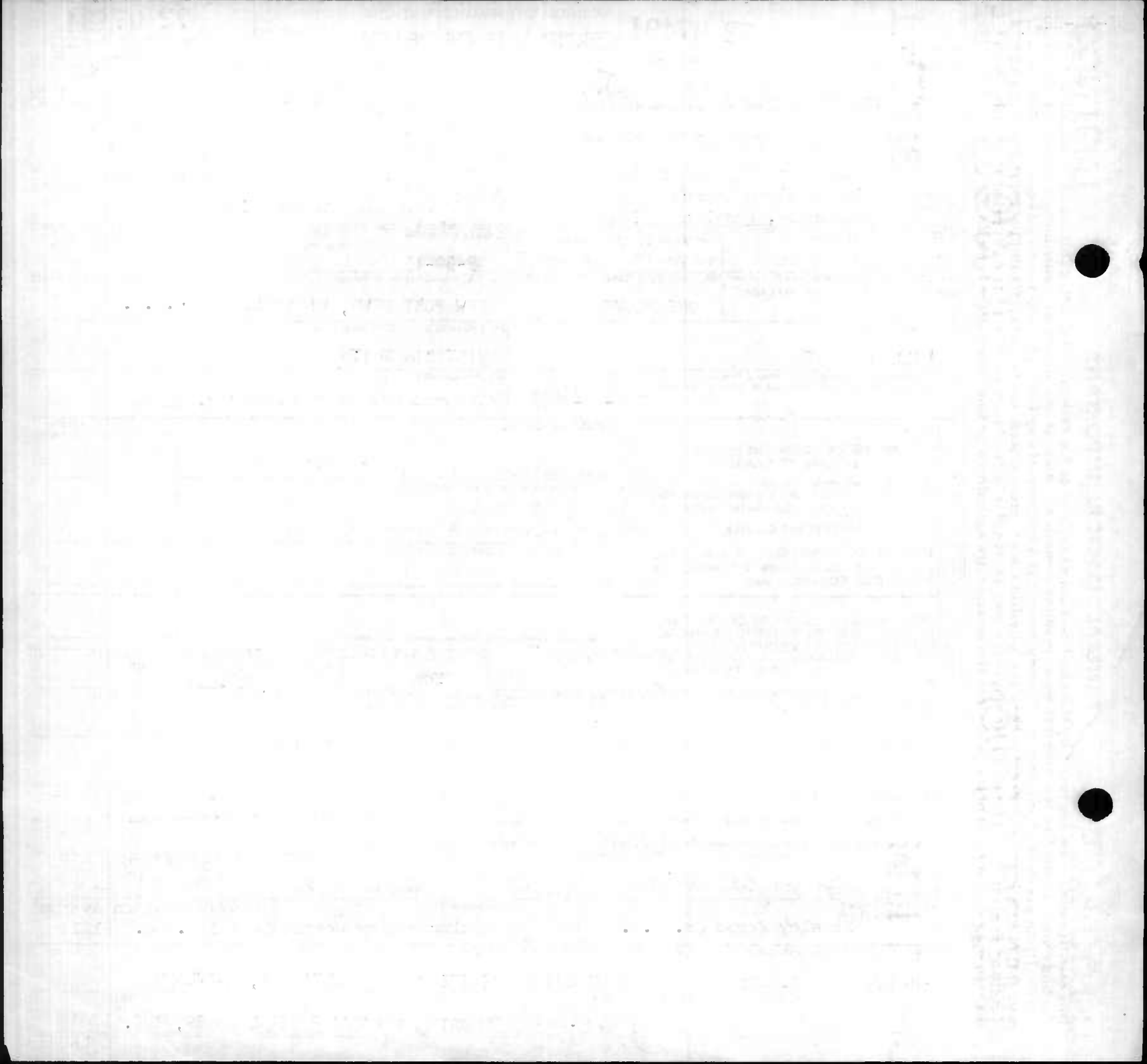
25C. FUNERAL DIRECTOR

MORTON & DYETT FUNERAL HOMES, INC. 1701

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

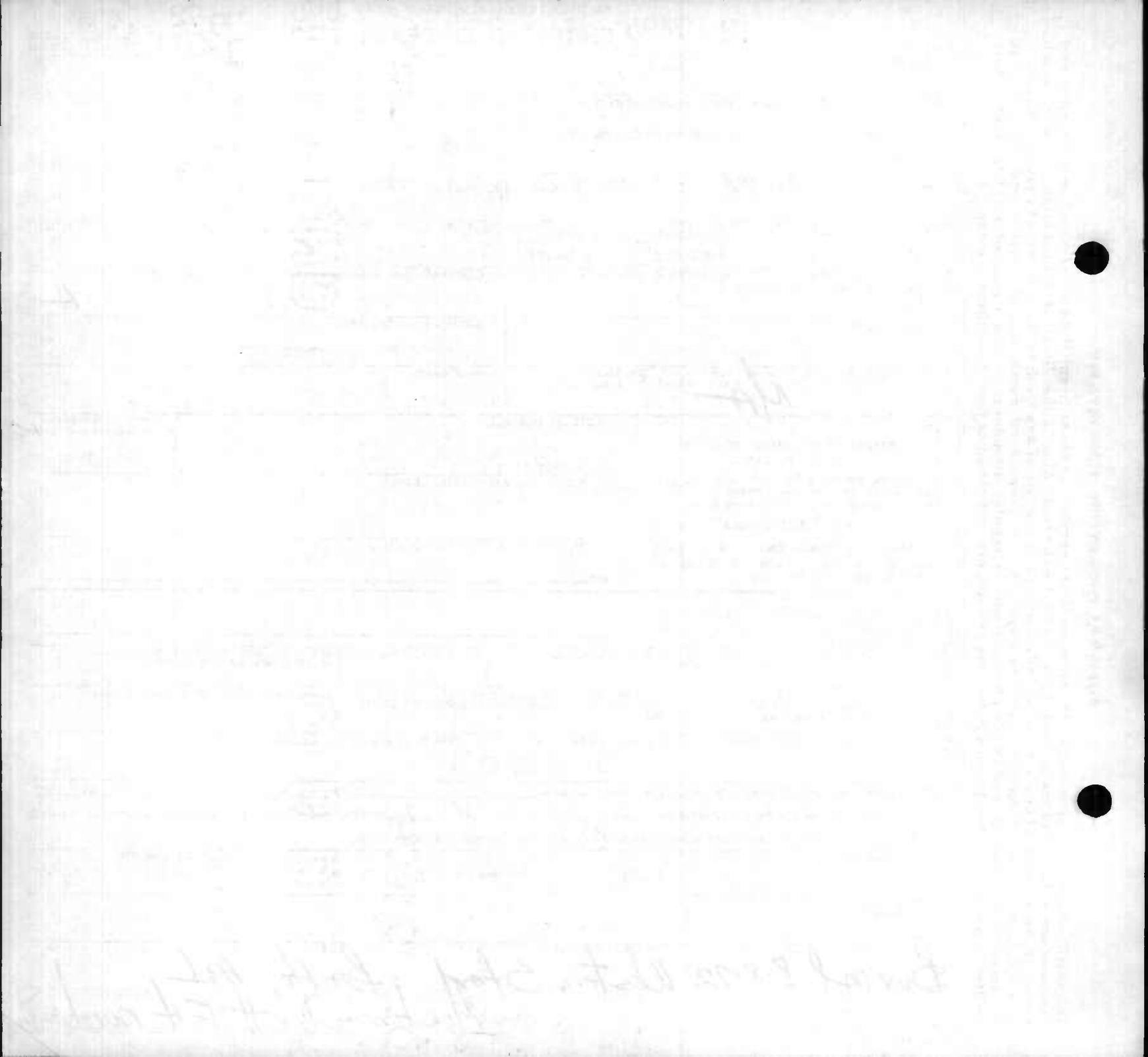
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 72 07495 | | 72 07495 | |
|--|---------------------|---|------------------------------------|---|-----------------------|---|------------------------|
| BIRTH NO. | | | | REG. NO. | | STATE OF MARYLAND-DHMH | |
| 1. NAME OF DECEASED (Type or Print) LOISE F. WATKINS | | | | 2. DATE AND HOUR OF DEATH 8/4/72 9:55 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 1605 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 2430 Edmondson Ave. | | | |
| 5. SEX F | 6. RACE N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/23/20 | 9. AGE (In years last birthday) 52 | If Under 1 Yr. Months | If Under 24 Hrs. Days | If Under 24 Hrs. Hours |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Worker | | 10B. KIND OF BUSINESS OR INDUSTRY Domestic | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Caruso Franklin | | | | 14. MOTHER'S MAIDEN NAME Etta Franklin Wiggins | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NA | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Joyce Brown | | ADDRESS 2807 Greenlawn Rd Baltimore Md 21207 | |
| 18. 1997 I 1 CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Adenocarcinoma 1 site unknown | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 2 yrs. | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 19 1972 to Aug 4 1972 and that (I) (we) last saw the deceased alive on Aug 4 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE J.R. DePaulo Jr MD | | | | 23B. DATE SIGNED 8/4/72 | | | |
| 23C. PHYSICIAN'S NAME (Type) J. Raymond DePaulo MD | | | | 23D. ADDRESS Johns Hopkins Hosp | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) Burial | | 24B. DATE 8-8-72 | | 24C. NAME OF CEMETERY OR CREMATORY Western Standard | | 24D. LOCATION (City, town, or county) (State) Ba Ho, Md | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 7 1972 | | 25B. NAME OF REGISTRAR Ldney W. Brown | | 25C. FUNERAL DIRECTOR Wet H. F. H | | ADDRESS 101-111 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 72 07496 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07496 | |
|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | STATE OF MARYLAND-DHMH | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <u>LILLIAN CARRINGTON</u> | | 2. DATE AND HOUR OF DEATH <u>AUG. 5/72</u> <u>7:15 A.M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>LUTHERAN HOSPITAL OF MARYLAND</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2844</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>LUTHERAN HOSPITAL OF MARYLAND</u> | | | | C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <u>F</u> | | 6. RACE <u>N</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH <u>12-1-02</u> | |
| | | <u>U.S. Gov.</u> | | 9. AGE (In years last birthday) <u>69</u> | |
| 13. FATHER'S NAME <u>Isiah C. Coffee</u> | | 14. MOTHER'S MAIDEN NAME <u>Harvella Coffee</u> | | 11. BIRTHPLACE (State or foreign country) <u>Rhine Georgia</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>217-22-4068</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| | | 17. INFORMANT <u>Harvey W. Carrington</u> | | ADDRESS <u>1110 Kevin Rd</u> | |
| 18. <u>4-369 I</u> | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | <u>CARDIORESPIRATORY ARREST</u> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <u>SEPTICEMIA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>CVA</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>6-8</u> 19 <u>72</u> to <u>8-5</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8-5</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Ruben Manriquez</u> | | | | 23B. DATE SIGNED <u>Aug 5-72</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>RUBEN MANRIQUEZ</u> | | | | 23D. ADDRESS <u>LUTHERAN HOSPITAL</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>8-9-72</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>St. Calvary</u> | |
| 24D. LOCATION (City, town, or county) <u>Balto Md</u> | | 24E. DATE REC'D BY HEALTH DEPT. <u>AUG 7 1972</u> | | 24F. NAME OF REGISTRAR <u>Andrew J. Brown</u> | |
| 24G. FUNERAL DIRECTOR <u>St. Lawrence</u> | | 24H. ADDRESS <u>1701 - Lawrence St.</u> | | | |

18-02-02

Kings, George

James H. C. 18-02-02

18-02-02

James H. C. 18-02-02

James H. C. 18-02-02

18-02-02

18-02-02

18-02-02

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 4-4301 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 72 07497 |
|---|--------------|---|---|---|
| 5-530 | | 72 07497 | | STATE OF MARYLAND-DEMET |
| BIRTH NO. | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) SLADELL (HOLT) Smith | | 2. DATE AND HOUR OF DEATH 12:15 am 4 th August M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY 1606 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL OF MARYLAND 46 | | C. CITY OR TOWN BALTIMORE | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER 730 ASHBURTON STREET | | |
| 5. SEX F | 6. RACE N | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-29-25 | 9. AGE (In years last birthday) 47 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY NA | 11. BIRTHPLACE (State or foreign country) Greenwood S.C. | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME James Smith | | 14. MOTHER'S MAIDEN NAME Daisy Smith | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Benjamin Holt-1602-Elham St |
| 18. 56741 | | CAUSE OF DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiorespiratory arrest (B) DUE TO, OR AS A CONSEQUENCE OF: Septic shock. (C) DUE TO, OR AS A CONSEQUENCE OF: Acute peritonitis. | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes. Hollers days. | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION 8-2-72 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ACUTE ABDOMEN | | 20A. AUTOPSY (Yes or No) Yes |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO |
| 21D. TIME OF INJURY (APPROX.) NO | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? — |
| 22. I certify that (I) (this hospital) attended the deceased from 8-2-1972 to 8-4-1972 that (I) (we) last saw the deceased alive on 8-4-72 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE Ernesto Morfino MD. | | 23B. DATE SIGNED 8/4/72 | | 23C. PHYSICIAN'S NAME (Type) ERNESTO MORFINO MD. |
| 23D. ADDRESS Lutheran Hospital of Md. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 8-8-72 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn |
| 24D. LOCATION Baltimore, Md. | | 24E. (State) | | |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 7 1972 | | 25B. NAME OF REGISTRAR Sandra Hinton | | 25C. FUNERAL DIRECTOR 3493 |

General
United States

United States

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07498

| | | | | | |
|---|-------------------------|--|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) ROBERT L. WILLIAMS | | 2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital | | 3. DATE PRONOUNCED DEAD Month Day Year Hour 8 3 1972 12:15a M. | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1703 | |
| 6. SEX male | 7. RACE negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | |
| 9. DATE OF BIRTH 10/25-1941 | | 10. AGE (In years last birthday) 30 | | E. STREET AND NUMBER 1055 Argyle Ave. | |
| 11. BIRTHPLACE (State or foreign country) Stoney Creek Va | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Robert L. Williams Jr | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME Gertrude Dillard | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT ADDRESS Gertrude W. Taylor, Stoney Creek Va | |
| 19. E-966 IX | | CAUSE OF DEATH Stabwound of chest | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) _____ DUE TO, OR AS A CONSEQUENCE OF: | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (C) _____ | | | |
| 20A. DATE OF OPERATION 8-3-72 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1055 Argyle Ave. 1703 | |
| 22D. TIME OF INJURY (APPROX.) 8-3-72 12:30 a.m. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? Stabbed by unknown assailant. | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-3-72 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | | 24B. DATE 8/4/72 | | 24C. NAME of CEMETERY or CREMATORY Family Plot | |
| 24D. LOCATION (City, town, or county) (State) Stoney Creek Va | | 25A. DATE REC'D BY HEALTH DEPT. AUG 7 1972 | | | |
| 25B. NAME OF REGISTRAR Sidney Whitson | | 25C. FUNERAL DIRECTOR ADDRESS Marshall R. Hyatt 6387 film | | | |

UNITED STATES

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George A. Miller Jr.
Carmichael, Dallas
Carmichael, Dallas

George A. Miller Jr.
Carmichael, Dallas
Carmichael, Dallas

George A. Miller Jr.

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George A. Miller Jr.
Carmichael, Dallas
Carmichael, Dallas

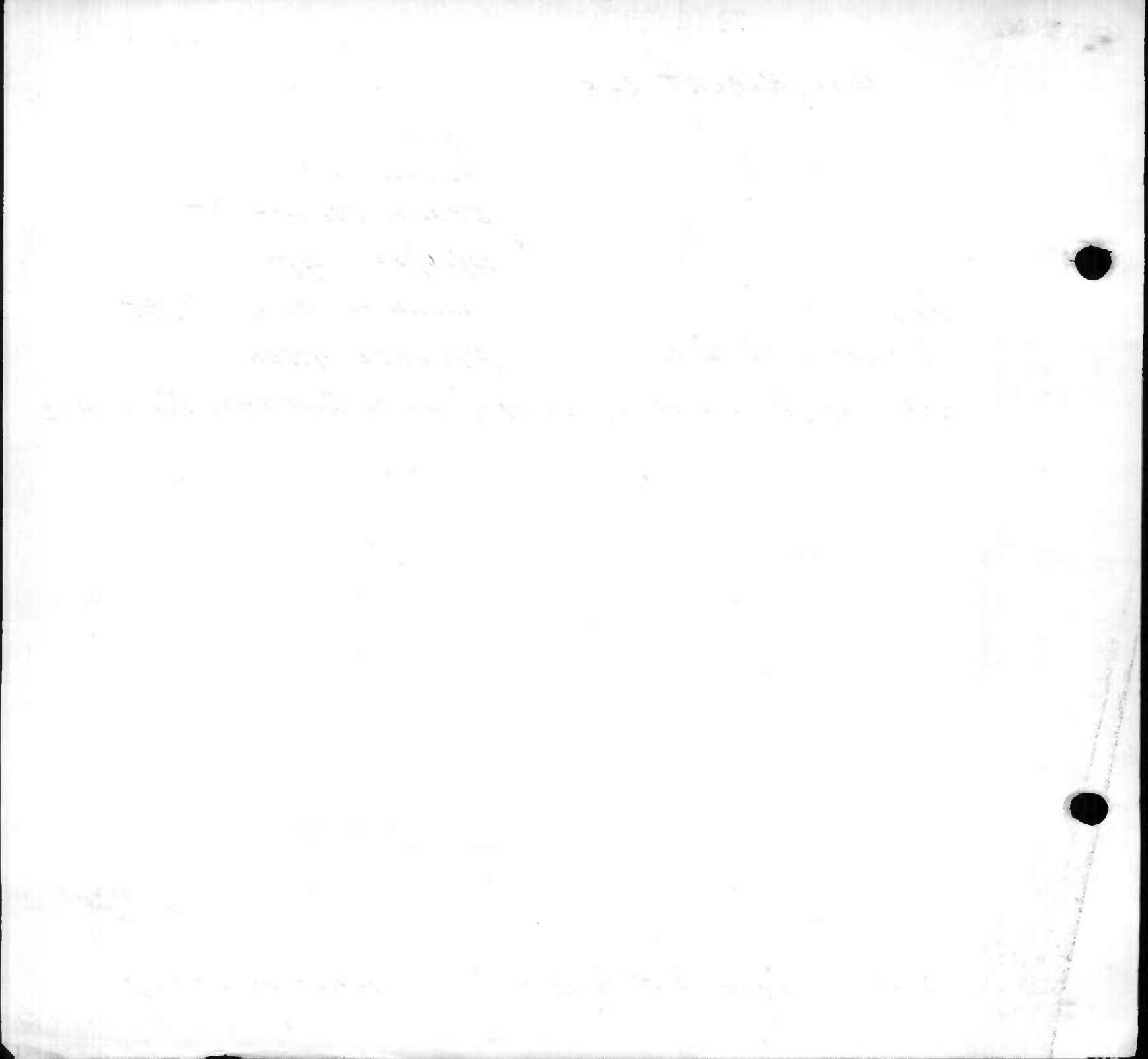
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07499 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 07499
STATE OF MARYLAND-DHMH

| | | | | | |
|---|-------------------------|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) GILL, ROBERT LEE | | 2. DATE AND HOUR OF DEATH 8-5-72 7-30 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 1603 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital 46 | | | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 532 N. Mount St | |
| 5. SEX male | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12/20/22 | 9. AGE (In years last birthday) 45 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Warrenton, N.C. | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME William M. Gill | | | | 14. MOTHER'S MAIDEN NAME Alvora Allen | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1/17/46 - 1-2-47 | | 16. SOCIAL SECURITY NO. 243 82 3687 | | 17. INFORMANT John W. Gill ADDRESS 3422 Royal Ave | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CHF (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CHF (B) DUE TO, OR AS A CONSEQUENCE OF: (C) | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Renal Failure. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> Notify medical examiner | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-20-1972 to 8-5-1972 that (I) (we) last saw the deceased alive on 8-5-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Sheffield M.D. | | | | 23B. DATE SIGNED 8-5-72 | |
| 23C. PHYSICIAN'S NAME (Type) JAWED H. SIDDIGI M.D. | | | | 23D. ADDRESS Lutheran Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burned | | 24B. DATE 8/8/72 | | 24C. NAME OF CEMETERY OR CREMATORY MA Arboretum | |
| 24D. LOCATION (City, town, or county) (State) Baltimore MD | | 25A. DATE REC'D BY HEALTH DEPT. AUG 7 1972 | | | |
| 25B. NAME OF REGISTRAR Sidney Johnston | | 25C. FUNERAL DIRECTOR Brooks & Blythe 185 N. 9th St | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 72 07500 | |
|---|-------------------------|--|------------------------------------|---|---|
| BIRTH NO. <u>72 07500</u> | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>NEIL CUNNINGHAM</u> | | STATE OF MARYLAND | | DATE AND HOUR OF DEATH <u>8/2/72</u> <u>9:20</u> A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>WASHINGTON</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>33 THE JOHNS HOPKINS HOSPITAL</u> | | C. CITY OR TOWN <u>CLEARSPRING,</u> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | E. STREET AND NUMBER <u>Box 425 Rt 1</u> | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-12-67</u> | 9. AGE (In years last birthday) <u>4</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>NEIL E. CUNNINGHAM</u> | | 14. MOTHER'S MAIDEN NAME <u>PATRICIA RODEHEAVER</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Mrs. Patricia Saunders R#1 Clearspring, Md. Box 425</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Aspiration Pneumonia</u> | | CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Septic Shock - severe brain damage</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> | | (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Meningococcal - s/p closure</u> | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u> | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Not Applicable</u> | |
| 21C. WHERE DID INJURY OCCUR? <u>Not Applicable</u> | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>9 AM - July 2</u> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <u>July 1</u> 19 <u>72</u> to <u>July 2</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>9 AM - July 2</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <u>John T. Hayford Jr. MD.</u> | | 23B. DATE SIGNED <u>8/2/72</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>JOHN T. HAYFORD JR MD.</u> | | 23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>8/5/72</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Hagerstown Washington Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 7 1972</u> | | 25B. NAME OF REGISTRAR <u>John T. Hayford Jr.</u> | |
| 25C. FUNERAL DIRECTOR <u>Wm. A. Norris</u> | | 25D. ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u> | | | |

